Board of Trustees' Meeting
Department of State Treasurer
Friday, August 1, 2014
9:00 a.m. – 3:00 p.m.

1. Welcome — Janet Cowell, Chair

2. Conflict of Interest Statement — Janet Cowell, Chair

3. Review of Minutes – May 28-29, 2014 ***(Requires Board Vote)*** — Janet Cowell, Chair

4. Executive Administrator Update — Mona Moon

5. Legislative Update — Tom Friedman

6. Financial Report, Forecasting and Monitoring — Mark Collins

   A. June 2014 Financial Report

   B. 2013-14 State Fiscal Year Financial Report

7. Benefit Design, Plan Options and Premiums

   A. 2015 Enrollment Rules – Medicare Retirees ***(Requires Board Vote)*** — Beth Horner

   B. ACA Preventive Medications & Services ***(Requires Board Vote)*** — Sally Morton, Nidu Menon

Break ***(10 minutes)***

   C. Update on Potential Benefit Option for Newly Eligibles — Mona Moon

8. Member Experience and Communications

A.	Segmentation Pilot	Nidu Menon Kim Wiese, Sr. V-P *Product Marketing and Strategy, ActiveHealth Management*
B.	Multipronged Pilot Initiative to Improve Member Health	Nidu Menon

Lunch *(30 minutes)*

C.	Annual Enrollment Outreach Plan	Beth Horner
D.	Other Member Outreach Initiatives	Beth Horner

9. Contracting and Vendor Partnerships

A.	Contract with NC Hospital Foundation for ADT Data ***(Requires Board Vote)***	Lotta Crabtree Nidu Menon

10.	Strategic Planning	Tom Gualtieri-Reed
11.	Executive Session (for Board members only) *Pursuant to: G.S. 143-318.11 and G.S. 132-1.2*	Janet Cowell, Chair

A.	Lake Lawsuit (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.) *(G.S. §143.318.11(a)(3))*	Lotta Crabtree Mark Bernstein
B.	Consultation with Legal Counsel – Contract Issue *(G.S. §143.318.11(a)(3) and G.S. § 132-1.2)*	Lotta Crabtree

12.	Wrap-Up	Janet Cowell, Chair

Next Board of Trustees' Meeting: Thursday, September 18, 4-6 p.m. and Friday, September 19, 9 a.m. – 3 p.m.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Legislative Update

Board of Trustees

August 1, 2014

A Division of the Department of State Treasurer

Legislative Update Overview

- State Budget Update
- Summary of State Health Plan related Legislation
- Next Steps

State Health Plan Budget Update

- The State Treasurer, in consultation with the Board, recommended foregoing scheduled increases in employer and employee premiums in CY 2015
  - The Appropriations Act of 2013, (the budget enacted by SL 2013-360) includes funding in FY 2014-15 to increase the employer contribution for health benefits by 2.14% in January 2015
  - Foregoing the premium increase will save $22 million in General Fund and $1.05 million in Highway Fund Appropriations
- The Governor's Recommended Budget (SB 842), the proposed Senate Budget (SB 744, 3rd Edition), the House Budget (SB 744, 7th Edition), and the Proposed Conference Committee Report include the savings associated with foregoing the premium increase

State Health Plan Budget Update

	Enacted Budget (SL 2013-360)	Governor's Recommended Budget	Senate Budget Proposal	House Budget Proposal	Proposed Conference Report
Premium Increase					
FY 2014-15	2.14% Jan 1, 2015	0.00%	0.00%	0.00%	0.00%
General Fund Appropriations					
FY 2014-15	$89.0 m	$67.0 m	$67.0 m	$67.0 m	$67.0 m
Change	N/A	($22.0 m)	($22.0 m)	($22.0 m)	($22.0 m)
Highway Fund Appropriations					
FY 2014-15	$4.5 m	$3.45 m	$3.45 m	$3.45 m	$3.45 m
Change	N/A	($1.05 m)	($1.05 m)	($1.05 m)	($1.05 m)

Additional Budget Items Related to the State Health Plan

Proposed Conference Report:

- Increases the Plan's administrative budget by $12.8 million to reflect revised estimates of contractual and agency administrative costs
- Alternative health benefit coverage for nonpermanent full-time state employees
  - Creates a new eligibility category for nonpermanent full-time employees to comply with the Affordable Care Act
  - Directs the Treasurer and Board to determine the coverage and contributions for these "newly eligible" employees as follows:
    - Minimum essential coverage, no greater than "Bronze" level, minimize employer contribution
  - UNC did not receive authorization to provide their own plan for newly eligible in the Conference Report

HB 498: Autism Health Insurance Coverage

- **Bill Summary:**
  - Requires the Plan to provide annual coverage of $36,000 for autism behavioral treatment benefits (some benefits not covered currently) for individuals age 23 and under
  - Exempts Board Certified Behavior Analysts (BcBAs) from the Psychology Practice Act to enable them to treat patients within the scope of their national certification, so long as they do not represent themselves to be psychologists
- **Status:** Passed the House, referred to Senate Committee on Insurance
  - Monitoring closely as the Plan needs to be exempt if legislation is enacted given the Board approved benefit for applied behavior analysis differs on certain elements
- **Fiscal Impact:** Increase Plan costs by
  - $3.3 to $5.1 million in FY 2014-15
  - $6.1 to $12.7 million annually in the long term
  - Based on legislative actuarial note

SB 493: Health and Safety Regulatory Reform

- **Bill Summary:**
  - Requires health benefit plans to provide coverage for autism spectrum disorders, similar to HB 498 but excludes the Plan
  - Establishes a North Carolina licensure board for Behavioral Analysts
    - Currently, under the State Health Plan's benefit BCBAs will need to practice under the license of a psychologists
  - Other health provisions not related to the Plan
    - Oral Chemotherapy Copay Parity
    - Pharmacy Benefit Management Regulations
      - Revisions to maximum allowable costs
- **Status:**
  - Passed House, Referred to Senate Committee on Ways & Means
    - Alternate legislation is being considered in the Senate, but may be included in another bill
- **Fiscal Impact:** None

SB 105: Add Towns to the State Health Plan

- **Bill Summary:**
  - Allows active employees (and their dependents) of the cities of Matthews and Elizabethtown to enroll in the State Health Plan
    - Does not permit their retirees to enroll in the Plan
- **Status**: Signed by Governor, SL 2014-75
- **Fiscal Impact**:
  - Segal Actuarial Note – Net Increase in Plan Cost
    - FY 2014-15: $206,000
    - FY 2015-16: $293,000
    - FY 2016-17: $314,000
  - Hartman Associates:
    - Elizabethtown: Neglible; Matthews: $80,000 to $250,000 per year
  - Based on the legislative actuarial note

SB 376: Montgomery County Employees in State Health Plan

- **Bill Summary:**
  - Allows active employees (and their dependents) of Montgomery County to enroll in the State Health Plan
    - Does not permit their retirees to enroll in the Plan
- **Status:** Ratified, Presented to Governor
- **Fiscal Impact**:
  - Segal Actuarial Note – Net Increase in Plan Cost
    - FY 2014-15: $443,000
    - FY 2015-16: $631,000
    - FY 2016-17: $675,000
  - Hartman Associates:
    - Slight gain to net cost $195,000 per year
  - Based on the legislative actuarial note

SB 783: Establish Chiropractor Co-pay Parity

- **Bill Summary:**
  - Requires the Plan to cover chiropractic care at the PCP copay level
  - Removes covered limits on visits to chiropractor
- **Status:** Referred to Senate Committee on Insurance
- **Fiscal Impact:** Increase Plan costs by
  - $0.8 to $1.6 million in FY 2014-15
  - $2.1 to $3.9 million in FY 2015-16
  - Based on the legislative actuarial note

Next Steps

- Update the Board on final Revised Budget
- Track SHP-related legislation, technical corrections, and appointments bills
- Communicate Plan’s position on SHP related legislation

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES

June 2014 Financial Report

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted Calendar Year to Date June 2014

Calendar Year 2014	Actual thru Jun 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$1.481 b**	**$1.485 b**	**($4.0 m)**
Net Claims Payments	$1.203 b	$1.285 b	($81.4 m)
Medicare Advantage Premiums	$78.5 m	$86.8 m	($8.3 m)
Net Administrative Expenses	$78.6 m	$91.2 m	($12.6 m)
Total Plan Expenses	**$1.361 b**	**$1.463 b**	**($102.3 m)**
Net Income/(Loss)	**$120.1 m**	**$21.8 m**	**$98.3 m**
Ending Cash Balance	**$958.6 m**	**$716.8 m**	**$241.8 m**

Adjusted Variance Report
Calendar Year to Date June 2014

Calendar Year 2014	Actual thru June 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$1.518 b**	**$1.485 b**	**$33.5 m**
Net Claims Payments ^	$1.196 b	$1.285 b	($88.7 m)
Medicare Advantage Premiums	$78.5 m	$86.8 m	($8.3 m)
Net Administrative Expenses †	$70.1 m	$91.2 m	($21.1 m)
Total Plan Expenses	**$1.345 b**	**$1.463 b**	**($118.1 m)**
Net Income/(Loss)	**$173.4 m**	**$21.8 m**	**$151.6 m**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.
† Adjusted for timing issues.

Financial Results Actual v. Budgeted Calendar Year to Date June 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru June 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$363.61**	**$371.61**	**($8.00)**
Net Claims Payments	$296.38	$321.36	($24.98)
Medicare Advantage Premiums	$19.34	$21.73	($2.39)
Net Administrative Expenses	$19.36	$22.80	($3.44)
Total Plan Expenses	**$335.08**	**$365.89**	**($30.81)**
Net Income/(Loss)	**$28.53**	**$5.72**	**$22.81**

Comparing actual results to the budget projection on a PMPM basis helps correct for changes in membership that occurred during the year.

Adjusted Variance Report
Calendar Year to Date June 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru June 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$372.83**	**$371.61**	**$1.22**
Net Claims Payments ^	$294.58	$321.36	($26.78)
Medicare Advantage Premiums	$19.34	$21.73	($2.39)
Net Administrative Expenses †	$17.26	$22.80	($5.54)
Total Plan Expenses	**$331.18**	**$365.89**	**($34.71)**
Net Income/(Loss)	**$41.65**	**$5.72**	**$35.93**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.
† Adjusted for timing issues.

Plan Year to Date Expenditure Trend Per Member Per Month

Allocation of Claims Expenditures

Calendar Year to Date June 2014

Includes Medical, Blue Card & Pharmacy Payments

Pharmacy 24%

Dental 0%

Inpatient Facility 19%

Professional 30%

Other 3%

Outpatient Facility 24%

Source: BCBSNC Summary of Billed Charges

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended June 2014

Calendar Year 2014

#		A	B	C	D	E	F	G	H
		Actual June 2014	Certified Budget June 2014	Monthly Variance Over/(Under) Certified Budget	Actual 2014 Calendar Year To Date	Certified Budget 2014 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Certified Budget	Calendar Year Certified Budget (Jan- Dec 2014)	Calendar Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 239,533,989	$ 243,531,900	$ (3,997,911)	$ 1,438,519,678	$ 1,462,487,643	$ (23,967,965)	$ 2,921,878,532	$ (1,483,358,854)
4	Premium Refunds/Retroactive Disenrollments	(30)	(124,138)	124,108	(22,385)	(745,476)	723,091	(1,489,408)	1,467,023
5	Medicare Part D (RDS) Subsidy	1,282,754	519,277	763,477	12,907,540	3,434,018	9,473,522	6,344,076	6,563,464
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	26,697,984	17,999,101	8,698,883	31,047,005	(4,349,021)
7	Medicare Advantage (MA) Subsidy	111,598	-	111,598	417,565	-	417,565	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**240,928,311**	**243,927,039**	**(2,998,728)**	**1,478,520,382**	**1,483,175,286**	**(4,654,904)**	**2,957,780,205**	**(1,479,259,823)**
10									
11	Investment Earnings	369,223	244,520	124,703	2,075,148	1,420,129	655,019	2,892,005	(816,857)
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	**369,223**	**244,520**	**124,703**	**2,075,148**	**1,420,129**	**655,019**	**2,892,005**	**(816,857)**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**241,297,534**	**244,171,559**	**(2,874,025)**	**1,480,595,530**	**1,484,595,415**	**(3,999,885)**	**2,960,672,210**	**(1,480,076,680)**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	185,033,694	202,906,472	(17,872,778)	956,416,933	1,063,493,817	(107,076,884)	2,062,826,346	(1,106,409,413)
20	Medical Claim Refunds/Recoveries	(1,276,891)	(2,215,314)	938,423	(11,616,388)	(12,583,200)	966,812	(25,469,051)	13,852,663
21	**Net Medical Claims**	**183,756,803**	**200,691,158**	**(16,934,355)**	**944,800,545**	**1,050,910,617**	**(106,110,072)**	**2,037,357,295**	**(1,092,556,750)**
22									
23	Pharmacy Claim Payments	50,170,813	43,164,795	7,006,018	317,864,645	265,605,138	52,259,507	599,541,594	(281,676,949)
24	Pharmacy Claim Rebates	-	-	-	(59,464,464)	(31,780,500)	(27,683,964)	(54,794,623)	(4,669,841)
25	Pharmacy Claim Refunds/Recoveries	93,603	-	93,603	158,878	-	158,878	-	158,878
26	**Net Pharmacy Claims**	**50,264,416**	**43,164,795**	**7,099,621**	**258,559,059**	**233,824,638**	**24,734,421**	**544,746,971**	**(286,187,912)**
27									
28	**Net Claim Payments**	**234,021,219**	**243,855,953**	**(9,834,734)**	**1,203,359,604**	**1,284,735,255**	**(81,375,651)**	**2,582,104,266**	**(1,378,744,662)**
29									
30	**Medicare Advantage Premium Payments**	**12,382,444**	**14,507,486**	**(2,125,042)**	**78,538,847**	**86,864,744**	**(8,325,897)**	**174,162,733**	**(95,623,886)**
31									
32	**Net Administrative Expenses**	**13,001,226**	**15,181,071**	**(2,179,845)**	**78,586,176**	**91,148,330**	**(12,562,154)**	**179,815,010**	**(101,228,834)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**259,404,889**	**273,544,510**	**(14,139,621)**	**1,360,484,627**	**1,462,748,329**	**(102,263,702)**	**2,936,082,009**	**(1,575,597,382)**
35									
36	**Plan Income/(Loss)**	**(18,107,355)**	**(29,372,951)**	**11,265,596**	**120,110,903**	**21,847,086**	**98,263,817**	**24,590,201**	**95,520,702**
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	976,665,395	746,195,170	230,470,225	838,447,137	694,975,133	143,472,004	694,975,133	143,472,004
41	**Ending Cash Balance/(Deficit)**	**958,558,040**	**716,822,219**	**241,735,821**	**958,558,040**	**716,822,219**	**241,735,821**	**719,565,334**	**238,992,706**
42									
43	Target Stabilization Reserve @ 12/31/14	234,282,695	234,282,695	-	234,282,695	234,282,695	-	234,282,695	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	**$ 724,275,345**	**$ 482,539,524**	**$ 241,735,821**	**$ 724,275,345**	**$ 482,539,524**	**$ 241,735,821**	**$ 485,282,639**	**$ 238,992,706**

Comments:

a. Premium receivables totaled $102,374.34 as of June 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $36,751,360.60 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $25,085,406.50 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Calendar Year 2014.
e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended June 2014
Fiscal Year 2013- 2014

#		A	B	C	D	E	F	G	H
		Actual June 2014	Certified Budget June 2014	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2013-14	Certified Budget Year to Date FY 2013-14	Year to Date Variance Over/(Under) Certified Budget	Annual Certified Budget FY 2013-14	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 239,533,989	$ 243,531,900	$ (3,997,911)	$ 2,941,097,678	$ 2,902,567,015	$ 38,530,663	$ 2,902,567,015	$ 38,530,663
4	Premium Refunds/Retroactive Disenrollments	(30)	(124,138)	124,108	(299,923)	(1,466,766)	1,166,843	(1,466,766)	1,166,843
5	Medicare Part D (RDS) Subsidy	1,282,754	519,277	763,477	11,583,652	6,218,762	5,364,890	6,218,762	5,364,890
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	63,780,569	50,346,402	13,434,167	50,346,402	13,434,167
7	Medicare Advantage (MA) Subsidy	111,598	-	111,598	417,565	-	417,565	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**240,928,311**	**243,927,039**	**(2,998,728)**	**3,016,579,541**	**2,957,665,413**	**58,914,128**	**2,957,665,413**	**58,914,128**
10									
11	Investment Earnings	369,223	244,520	124,703	3,861,263	2,868,131	993,132	2,868,131	993,132
12	Miscellaneous Revenue	-	-	-	54,972	-	54,972	-	54,972
13	**Other Revenue**	**369,223**	**244,520**	**124,703**	**3,916,235**	**2,868,131**	**1,048,104**	**2,868,131**	**1,048,104**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**241,297,534**	**244,171,559**	**(2,874,025)**	**3,020,495,776**	**2,960,533,544**	**59,962,232**	**2,960,533,544**	**59,962,232**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	185,033,694	202,906,472	(17,872,778)	1,989,574,333	2,107,493,114	(117,918,781)	2,107,493,114	(117,918,781)
20	Medical Claim Refunds/Recoveries	(1,276,891)	(2,215,314)	938,423	(22,450,766)	(24,643,884)	2,193,118	(24,643,884)	2,193,118
21	**Net Medical Claims**	**183,756,803**	**200,691,158**	**(16,934,355)**	**1,967,123,567**	**2,082,849,230**	**(115,725,663)**	**2,082,849,230**	**(115,725,663)**
22									
23	Pharmacy Claim Payments	50,170,813	43,164,795	7,006,018	743,680,114	699,653,578	44,026,536	699,653,578	44,026,536
24	Pharmacy Claim Rebates	-	-	-	(91,653,105)	(52,353,361)	(39,299,744)	(52,353,361)	(39,299,744)
25	Pharmacy Claim Refunds/Recoveries	93,603	-	93,603	(398,652)	-	(398,652)	-	(398,652)
26	**Net Pharmacy Claims**	**50,264,416**	**43,164,795**	**7,099,621**	**651,628,357**	**647,300,217**	**4,328,140**	**647,300,217**	**4,328,140**
27									
28	**Net Claim Payments**	**234,021,219**	**243,855,953**	**(9,834,734)**	**2,618,751,924**	**2,730,149,447**	**(111,397,523)**	**2,730,149,447**	**(111,397,523)**
29									
30	**Medicare Advantage Premium Payments**	**12,382,444**	**14,507,486**	**(2,125,042)**	**78,538,847**	**86,864,744**	**(8,325,897)**	**86,864,744**	**(8,325,897)**
31									
32	**Net Administrative Expenses**	**13,001,226**	**15,181,071**	**(2,179,845)**	**148,134,913**	**182,446,628**	**(34,311,715)**	**182,446,628**	**(34,311,715)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**259,404,889**	**273,544,510**	**(14,139,621)**	**2,845,425,684**	**2,999,460,819**	**(154,035,135)**	**2,999,460,819**	**(154,035,135)**
35									
36	**Plan Income/(Loss)**	**(18,107,355)**	**(29,372,951)**	**11,265,596**	**175,070,092**	**(38,927,275)**	**213,997,367**	**(38,927,275)**	**213,997,367**
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	976,665,395	746,195,170	230,470,225	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
41	**Ending Cash Balance/(Deficit)**	**958,558,040**	**716,822,219**	**241,735,821**	**958,558,040**	**716,822,219**	**241,735,821**	**716,822,219**	**241,735,821**
42									
43	Target Stabilization Reserve @ 6/30/14	239,446,206	239,446,206	-	239,446,206	239,446,206	-	239,446,206	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	**$ 719,111,834**	**$ 477,376,013**	**$ 241,735,821**	**$ 719,111,834**	**$ 477,376,013**	**$ 241,735,821**	**$ 477,376,013**	**$ 241,735,821**

Comments:
a. Premium receivables totaled $102,374.34 as of June 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $36,751,360.60 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $25,085,406.50 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2013-14.
e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended June 2014
Fiscal Year 2013-2014

#		A	B	C	D	E	F	G
		Current Year Actual June 2014	Prior Year Actual June 2013	Current Year to Date Actual FY 2013-14 thru June	Prior Year to Date Actual FY 2012-13 thru June	Current Year Certified Annual Budget FY 2013-14	Prior Year Annual Budget FY 2012-13	Prior Year Actual Results FY 2012-13
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 239,533,989	$ 231,487,077	$ 2,941,097,678	$ 2,895,366,140	$ 2,902,567,015	$ 2,872,808,844	$ 2,895,366,140
4	Premium Refunds/Retroactive Disenrollments	(30)	(51,743)	(299,923)	(487,819)	(1,466,766)	(1,437,243)	(487,819)
5	Medicare Part D (RDS) Subsidy	1,282,754	540,586	11,583,652	38,056,016	6,218,762	39,519,892	38,056,016
6	Medicare PDP (EGWP + Wrap) Subsidy	-	3,989,104	63,780,569	24,435,483	50,346,402	19,759,856	24,435,483
7	Medicare Advantage (MA) Subsidy	111,598	-	417,565	-	-	-	-
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(558,219)	-	-	(558,219)
9	**Net Premium & Other Contributions**	**240,928,311**	**235,965,024**	**3,016,579,541**	**2,956,811,601**	**2,957,665,413**	**2,930,651,349**	**2,956,811,601**
10								
11	Investment Earnings	369,223	295,603	3,861,263	3,117,666	2,868,131	5,658,262	3,117,666
12	Miscellaneous Revenue	-	-	54,972	119,047	-	-	119,047
13	**Other Revenue**	**369,223**	**295,603**	**3,916,235**	**3,236,713**	**2,868,131**	**5,658,262**	**3,236,713**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**241,297,534**	**236,260,627**	**3,020,495,776**	**2,960,048,314**	**2,960,533,544**	**2,936,309,611**	**2,960,048,314**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	185,033,694	160,836,063	1,989,574,333	1,858,096,405	2,107,493,114	2,003,583,417	1,858,096,405
20	Medical Claim Refunds/Recoveries	(1,276,891)	(1,594,137)	(22,450,766)	(23,467,914)	(24,643,884)	(31,216,928)	(23,467,914)
21	**Net Medical Claims**	**183,756,803**	**159,241,926**	**1,967,123,567**	**1,834,628,491**	**2,082,849,230**	**1,972,366,489**	**1,834,628,491**
22								
23	Pharmacy Claim Payments	50,170,813	64,053,421	743,680,114	755,896,440	699,653,578	743,853,418	755,896,440
24	Pharmacy Claim Rebates	-	-	(91,653,105)	(69,641,941)	(52,353,361)	(53,173,873)	(69,641,941)
25	Pharmacy Claim Refunds/Recoveries	93,603	(24,328)	(398,652)	(3,476,790)	-	-	(3,476,790)
26	**Net Pharmacy Claims**	**50,264,416**	**64,029,093**	**651,628,357**	**682,777,709**	**647,300,217**	**690,679,545**	**682,777,709**
27								
28	**Net Claim Payments**	**234,021,219**	**223,271,019**	**2,618,751,924**	**2,517,406,200**	**2,730,149,447**	**2,663,046,034**	**2,517,406,200**
29								
30	**Medicare Advantage Premium Payments**	**12,382,444**	**-**	**78,538,847**	**-**	**86,864,744**	**-**	**-**
31								
32	**Net Administrative Expenses**	**13,001,226**	**13,364,005**	**148,134,913**	**161,401,639**	**182,446,628**	**189,387,392**	**161,401,639**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**259,404,889**	**236,635,024**	**2,845,425,684**	**2,678,807,839**	**2,999,460,819**	**2,852,433,426**	**2,678,807,839**
35								
36	**Plan Income/(Loss)**	**(18,107,355)**	**(374,397)**	**175,070,092**	**281,240,475**	**(38,927,275)**	**83,876,185**	**281,240,475**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	976,665,395	783,862,343	783,487,948	502,247,471	755,749,494	502,247,475	502,247,471
41	**Ending Cash Balance/(Deficit)**	**958,558,040**	**783,487,946**	**958,558,040**	**783,487,946**	**716,822,219**	**586,123,660**	**783,487,946**
42								
43	Target Stabilization Reserve @ 6/30/14	239,446,206	199,728,453	239,446,206	199,728,453	239,446,206	199,728,453	188,805,465
44								
45	**Cash Balance Over/(Under) Reserve Target**	**$ 719,111,834**	**$ 583,759,493**	**$ 719,111,834**	**$ 583,759,493**	**$ 477,376,013**	**$ 386,395,207**	**$ 594,682,481**

Comments:
a. Minor differences compared to other reports are due to rounding

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended June 2014
Calendar Year 2014

#		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru June	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru June	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 1,438,519,678	$ 44,813,815	$ 1,483,333,493	$ 1,462,487,643	$ 20,845,850	1.43%
4	Premium Refunds/Retroactive Disenrollments	(22,385)		(22,385)	(745,476)	723,091	-97.00%
5	Medicare Part D (RDS) Subsidy (Note 3)	12,907,540	(6,855,182)	6,052,358	3,434,018	2,618,340	76.25%
6	Medicare PDP (EGWP + Wrap) Subsidy	26,697,984		26,697,984	17,999,101	8,698,883	48.33%
7	Medicare Advantage (MA) Subsidy (Note 4)	417,565	(417,565)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**1,478,520,382**	**37,541,068**	**1,516,061,450**	**1,483,175,286**	**32,886,164**	**2.22%**
10							
11	**Other Revenue**	**2,075,148**		**2,075,148**	**1,420,129**	**655,019**	**46.12%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**1,480,595,530**	**37,541,068**	**1,518,136,598**	**1,484,595,415**	**33,541,183**	**2.26%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	944,800,545		944,800,545	1,050,910,617	(106,110,072)	-10.10%
18	Net Pharmacy Claims (Notes 5 and 6)	258,559,059	(7,277,575)	251,281,484	233,824,638	17,456,846	7.47%
19	**Net Claim Payments**	**1,203,359,604**	**(7,277,575)**	**1,196,082,029**	**1,284,735,255**	**(88,653,226)**	**-6.90%**
20							
21	**Medicare Advantage Premiums**	**78,538,847**		**78,538,847**	**86,864,744**	**(8,325,897)**	**-9.58%**
22							
23	**Net Administrative Expenses** (Note 7)	**78,586,176**	**(8,491,208)**	**70,094,968**	**91,148,330**	**(21,053,362)**	**-23.10%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**1,360,484,627**	**(15,768,782)**	**1,344,715,845**	**1,462,748,329**	**(118,032,484)**	**-8.07%**
26							
27	**Plan Income/(Loss)**	**120,110,903**	**53,309,851**	**173,420,754**	**21,847,086**	**151,573,668**	**693.79%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	838,447,137		838,447,137	694,975,133	143,472,004	20.64%
32	**Ending Cash Balance/(Deficit)**	**958,558,040**	**53,309,851**	**1,011,867,891**	**716,822,219**	**295,045,672**	**41.16%**
33							
34	Target Stabilization Reserve @ 12/31/2014	234,282,695		234,282,695	234,282,695	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 724,275,345**	**$ 53,309,851**	**$ 777,585,196**	**$ 482,539,524**	**$ 295,045,672**	**61.14%**

Adjustment Notes:
1. Member premiums adjusted to include $60.8 million in prepaid January premiums received in December 2013.
2. Member premiums adjusted to exclude $16.0 million in prepaid July premiums received in June.
3. Medicare Part D subsidy adjusted to exclude an unbudgeted subsidy refund related to prior plan years.
4. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
5. Pharmacy claims adjusted to exclude a $33.1 million claims payment that was budgeted for payment in December 2013 but was not paid until January 2014.
6. Pharmacy claims adjusted to remove the unbudgeted portion of a rebate true-up payment that was $25.8 million more than anticipated.
7. Administrative expenses adjusted to reflect normal vendor payment schedules.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended June 2014
Fiscal Year 2013-2014

#		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru June	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru June	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums **(Notes 1 and 2)**	$ 2,941,097,678	$ (5,665,448)	$ 2,935,432,230	$ 2,902,567,015	$ 32,865,215	1.13%
4	Premium Refunds/Retroactive Disenrollments	(299,923)		(299,923)	(1,466,766)	1,166,843	-79.55%
5	Medicare Part D (RDS) Subsidy	11,583,652		11,583,652	6,218,762	5,364,890	86.27%
6	Medicare PDP (EGWP + Wrap) Subsidy	63,780,569		63,780,569	50,346,402	13,434,167	26.68%
7	Medicare Advantage (MA) Subsidy **(Note 3)**	417,565	(417,565)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**3,016,579,541**	**(6,083,013)**	**3,010,496,528**	**2,957,665,413**	**52,831,115**	**1.79%**
10							
11	**Other Revenue (Note 4)**	**3,916,235**	**(54,973)**	**3,861,262**	**2,868,131**	**993,131**	**34.63%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**3,020,495,776**	**(6,137,986)**	**3,014,357,790**	**2,960,533,544**	**53,824,246**	**1.82%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	1,967,123,567		1,967,123,567	2,082,849,230	(115,725,663)	-5.56%
18	Net Pharmacy Claims **(Notes 5 and 6)**	651,628,357	31,605,817	683,234,174	647,300,217	35,933,957	5.55%
19	**Net Claim Payments**	**2,618,751,924**	**31,605,817**	**2,650,357,741**	**2,730,149,447**	**(79,791,706)**	**-2.92%**
20							
21	**Medicare Advantage Premiums**	**78,538,847**		**78,538,847**	**86,864,744**	**(8,325,897)**	**-9.58%**
22							
23	**Net Administrative Expenses**	**148,134,913**		**148,134,913**	**182,446,628**	**(34,311,715)**	**-18.81%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**2,845,425,684**	**31,605,817**	**2,877,031,501**	**2,999,460,819**	**(122,429,318)**	**-4.08%**
26							
27	**Plan Income/(Loss)**	**175,070,092**	**(37,743,803)**	**137,326,289**	**(38,927,275)**	**176,253,564**	**-452.78%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	783,487,948		783,487,948	755,749,494	27,738,454	3.67%
32	**Ending Cash Balance/(Deficit)**	**958,558,040**	**(37,743,803)**	**920,814,237**	**716,822,219**	**203,992,018**	**28.46%**
33							
34	Target Stabilization Reserve @ 6/30/14	239,446,206		239,446,206	239,446,206	-	
35							
36	Cash Balance Over/(Under) Reserve Target	$ 719,111,834	$ (37,743,803)	$ 681,368,031	$ 477,376,013	$ 203,992,018	42.73%

Adjustment Notes:
1. Member premiums adjusted to include $10.3 million in prepaid July premiums received in June 2013.
2. Member premiums adjusted to exclude $16.0 million in prepaid July premiums received in June 2014.
3. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
4. Other revenue adjusted to exclude unbudgeted reimbursement of prior year expenditures.
5. Pharmacy claims adjusted to exclude $5.8 million in unbudgeted EGWP rebates earned last fiscal year but not received until October 2013.
6. Pharmacy claims adjusted to remove the unbudgeted portion of a rebate true-up payment that was $25.8 million more than anticipated.

Adjusted Variance Report Based on Certified (Original) Budget
Fiscal Year to Date Through June 2014

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2013-14 State Fiscal Year Financial Report

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted Fiscal Year 2013-14

Fiscal Year 2013-14	Actual thru June 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	**$783.5 m**	**$755.7 m**	**$27.8 m**
Plan Revenue	**$3.020 b**	**$2.960 b**	**$60.0 m**
Net Claims Payments	$2.619 b	$2.730 b	($111.4 m)
Medicare Advantage Premiums	$78.5 m	$86.8 m	($8.3 m)
Net Administrative Expenses	$148.1 m	$182.4 m	($34.3 m)
Total Plan Expenses	**$2.845 b**	**$2.999 b**	**($154.0 m)**
Net Income/(Loss)	**$175.1 m**	**($38.9 m)**	**$214.0 m**
Ending Cash Balance	**$958.6 m**	**$716.8 m**	**$241.8 m**

Adjusted Variance Report
Fiscal Year 2013-14

Fiscal Year 2013-14	Actual thru June 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$3.014 b**	**$2.960 b**	**$53.8 m**
Net Claims Payments ^	$2.650 b	$2.730 b	($79.8 m)
Medicare Advantage Premiums	$78.5 m	$86.8 m	($8.3 m)
Net Administrative Expenses	$148.1 m	$182.4 m	($34.3 m)
Total Plan Expenses	**$2.877 b**	**$2.999 b**	**($122.4 m)**
Net Income/(Loss)	**$137.3 m**	**($38.9 m)**	**$176.2 m**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.

Financial Results Actual v. Budgeted Fiscal Year 2013-14

Per Member Per Month (PMPM) Analysis

Fiscal Year 2013-14	Actual thru June 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$373.08**	**$370.14**	**$2.94**
Net Claims Payments	$324.23	$341.10	($16.87)
Medicare Advantage Premiums	$9.72	$10.85	($1.13)
Net Administrative Expenses	$18.34	$22.79	($4.45)
Total Plan Expenses	**$352.29**	**$374.74**	**($22.45)**
Net Income/(Loss)	**$20.79**	**($4.60)**	**$25.39**

Comparing actual results to the budget projection on a PMPM basis helps correct for changes in membership that occurred during the year.

Adjusted Variance Report
Fiscal Year 2013-14

Per Member Per Month (PMPM) Analysis

Fiscal Year 2013-14	Actual thru June 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$372.32**	**$370.14**	**$2.18**
Net Claims Payments ^	$328.15	$341.10	($12.95)
Medicare Advantage Premiums	$9.72	$10.85	($1.13)
Net Administrative Expenses	$18.34	$22.79	($4.45)
Total Plan Expenses	**$356.21**	**$374.74**	**($18.53)**
Net Income/(Loss)	**$16.11**	**($4.60)**	**$20.71**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.

Fiscal Year 2013-14 Expenditure Trend
Per Member Per Month

Allocation of Claims Expenditures
Fiscal Year 2013-14

Includes Medical, Blue Card & Pharmacy Payments

Source: BCBSNC Summary of Billed Charges

Recent Historical Financial Results
Revenues and Expenses

*FY 2009 revenues include a $250 million general fund appropriation from the State.

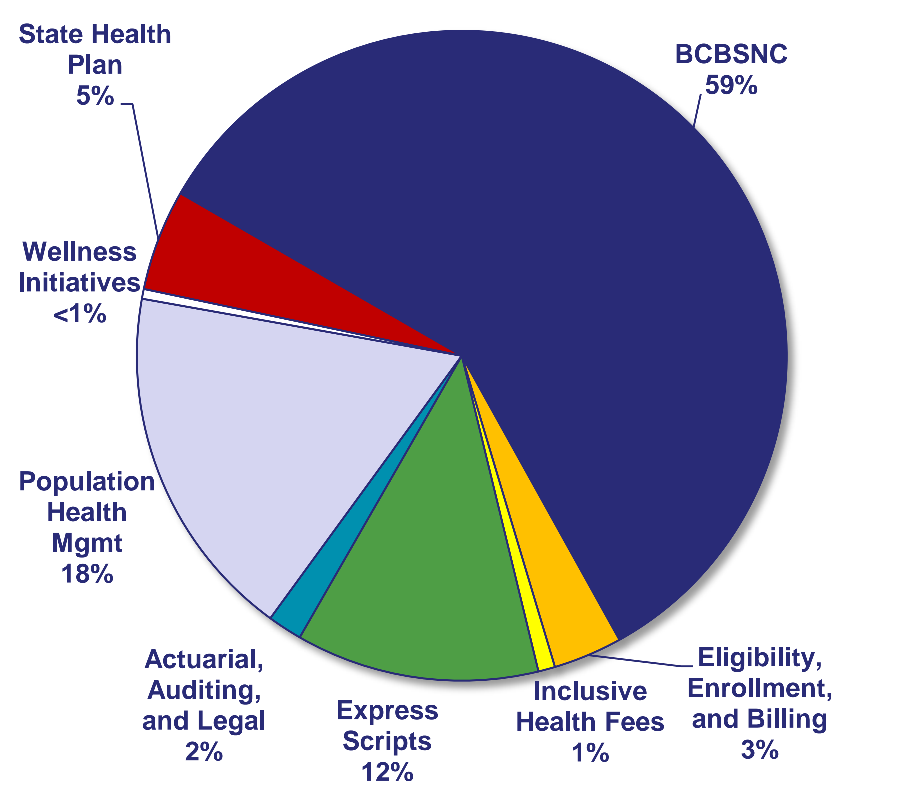
Recent Historical Financial Results
Net Income/(Loss) & Ending Cash Balance

*The Plan received a $250 million general fund appropriation from the State in FY 2009.

Recent Historical Financial Results
Expenditures (Claims + Administrative) PMPM

Fiscal Year 2013-14 Administrative Expenses

FY 2013-14 ($148.1 Million)



FY 2012-13 ($161.4 Million)

BCBSNC
67%

Includes eligibility, enrollment, and billing

State Health Plan
4%

Wellness Initiatives
<1%

Population Health Mgmt
16%

Actuarial, Auditing, Legal
2%

Express Scripts
11%

Inclusive Health Fees
<1%

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended June 2014
Fiscal Year 2013- 2014

#		A	B	C	D	E	F	G	H
		Actual June 2014	Certified Budget June 2014	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2013-14	Certified Budget Year to Date FY 2013-14	Year to Date Variance Over/(Under) Certified Budget	Annual Certified Budget FY 2013-14	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 239,533,989	$ 243,531,900	$ (3,997,911)	$ 2,941,097,678	$ 2,902,567,015	$ 38,530,663	$ 2,902,567,015	$ 38,530,663
4	Premium Refunds/Retroactive Disenrollments	(30)	(124,138)	124,108	(299,923)	(1,466,766)	1,166,843	(1,466,766)	1,166,843
5	Medicare Part D (RDS) Subsidy	1,282,754	519,277	763,477	11,583,652	6,218,762	5,364,890	6,218,762	5,364,890
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	63,780,569	50,346,402	13,434,167	50,346,402	13,434,167
7	Medicare Advantage (MA) Subsidy	111,598	-	111,598	417,565	-	417,565	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**240,928,311**	**243,927,039**	**(2,998,728)**	**3,016,579,541**	**2,957,665,413**	**58,914,128**	**2,957,665,413**	**58,914,128**
10									
11	Investment Earnings	369,223	244,520	124,703	3,861,263	2,868,131	993,132	2,868,131	993,132
12	Miscellaneous Revenue	-	-	-	54,972	-	54,972	-	54,972
13	**Other Revenue**	**369,223**	**244,520**	**124,703**	**3,916,235**	**2,868,131**	**1,048,104**	**2,868,131**	**1,048,104**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**241,297,534**	**244,171,559**	**(2,874,025)**	**3,020,495,776**	**2,960,533,544**	**59,962,232**	**2,960,533,544**	**59,962,232**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	185,033,694	202,906,472	(17,872,778)	1,989,574,333	2,107,493,114	(117,918,781)	2,107,493,114	(117,918,781)
20	Medical Claim Refunds/Recoveries	(1,276,891)	(2,215,314)	938,423	(22,450,766)	(24,643,884)	2,193,118	(24,643,884)	2,193,118
21	**Net Medical Claims**	**183,756,803**	**200,691,158**	**(16,934,355)**	**1,967,123,567**	**2,082,849,230**	**(115,725,663)**	**2,082,849,230**	**(115,725,663)**
22									
23	Pharmacy Claim Payments	50,170,813	43,164,795	7,006,018	743,680,114	699,653,578	44,026,536	699,653,578	44,026,536
24	Pharmacy Claim Rebates	-	-	-	(91,653,105)	(52,353,361)	(39,299,744)	(52,353,361)	(39,299,744)
25	Pharmacy Claim Refunds/Recoveries	93,603	-	93,603	(398,652)	-	(398,652)	-	(398,652)
26	**Net Pharmacy Claims**	**50,264,416**	**43,164,795**	**7,099,621**	**651,628,357**	**647,300,217**	**4,328,140**	**647,300,217**	**4,328,140**
27									
28	**Net Claim Payments**	**234,021,219**	**243,855,953**	**(9,834,734)**	**2,618,751,924**	**2,730,149,447**	**(111,397,523)**	**2,730,149,447**	**(111,397,523)**
29									
30	**Medicare Advantage Premium Payments**	**12,382,444**	**14,507,486**	**(2,125,042)**	**78,538,847**	**86,864,744**	**(8,325,897)**	**86,864,744**	**(8,325,897)**
31									
32	**Net Administrative Expenses**	**13,001,226**	**15,181,071**	**(2,179,845)**	**148,134,913**	**182,446,628**	**(34,311,715)**	**182,446,628**	**(34,311,715)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**259,404,889**	**273,544,510**	**(14,139,621)**	**2,845,425,684**	**2,999,460,819**	**(154,035,135)**	**2,999,460,819**	**(154,035,135)**
35									
36	**Plan Income/(Loss)**	**(18,107,355)**	**(29,372,951)**	**11,265,596**	**175,070,092**	**(38,927,275)**	**213,997,367**	**(38,927,275)**	**213,997,367**
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	976,665,395	746,195,170	230,470,225	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
41	**Ending Cash Balance/(Deficit)**	**958,558,040**	**716,822,219**	**241,735,821**	**958,558,040**	**716,822,219**	**241,735,821**	**716,822,219**	**241,735,821**
42									
43	Target Stabilization Reserve @ 6/30/14	239,446,206	239,446,206	-	239,446,206	239,446,206	-	239,446,206	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	**$ 719,111,834**	**$ 477,376,013**	**$ 241,735,821**	**$ 719,111,834**	**$ 477,376,013**	**$ 241,735,821**	**$ 477,376,013**	**$ 241,735,821**

Comments:
a. Premium receivables totaled $102,374.34 as of June 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $36,751,360.60 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $25,085,406.50 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2013-14.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (i.e. ***Original Budget*** per SL 2013-360 and Board Approved Design)
June 2014 - Fiscal Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended June 2014
Fiscal Year 2013-2014

#		A	B	C	D	E	F	G
		Current Year Actual June 2014	Prior Year Actual June 2013	Current Year to Date Actual FY 2013-14 thru June	Prior Year to Date Actual FY 2012-13 thru June	Current Year Certified Annual Budget FY 2013-14	Prior Year Annual Budget FY 2012-13	Prior Year Actual Results FY 2012-13
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 239,533,989	$ 231,487,077	$ 2,941,097,678	$ 2,895,366,140	$ 2,902,567,015	$ 2,872,808,844	$ 2,895,366,140
4	Premium Refunds/Retroactive Disenrollments	(30)	(51,743)	(299,923)	(487,819)	(1,466,766)	(1,437,243)	(487,819)
5	Medicare Part D (RDS) Subsidy	1,282,754	540,586	11,583,652	38,056,016	6,218,762	39,519,892	38,056,016
6	Medicare PDP (EGWP + Wrap) Subsidy	-	3,989,104	63,780,569	24,435,483	50,346,402	19,759,856	24,435,483
7	Medicare Advantage (MA) Subsidy	111,598	-	417,565	-	-	-	-
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(558,219)	-	-	(558,219)
9	**Net Premium & Other Contributions**	**240,928,311**	**235,965,024**	**3,016,579,541**	**2,956,811,601**	**2,957,665,413**	**2,930,651,349**	**2,956,811,601**
10								
11	Investment Earnings	369,223	295,603	3,861,263	3,117,666	2,868,131	5,658,262	3,117,666
12	Miscellaneous Revenue	-	-	54,972	119,047	-	-	119,047
13	**Other Revenue**	**369,223**	**295,603**	**3,916,235**	**3,236,713**	**2,868,131**	**5,658,262**	**3,236,713**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**241,297,534**	**236,260,627**	**3,020,495,776**	**2,960,048,314**	**2,960,533,544**	**2,936,309,611**	**2,960,048,314**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	185,033,694	160,836,063	1,989,574,333	1,858,096,405	2,107,493,114	2,003,583,417	1,858,096,405
20	Medical Claim Refunds/Recoveries	(1,276,891)	(1,594,137)	(22,450,766)	(23,467,914)	(24,643,884)	(31,216,928)	(23,467,914)
21	**Net Medical Claims**	**183,756,803**	**159,241,926**	**1,967,123,567**	**1,834,628,491**	**2,082,849,230**	**1,972,366,489**	**1,834,628,491**
22								
23	Pharmacy Claim Payments	50,170,813	64,053,421	743,680,114	755,896,440	699,653,578	743,853,418	755,896,440
24	Pharmacy Claim Rebates	-	-	(91,653,105)	(69,641,941)	(52,353,361)	(53,173,873)	(69,641,941)
25	Pharmacy Claim Refunds/Recoveries	93,603	(24,328)	(398,652)	(3,476,790)	-	-	(3,476,790)
26	**Net Pharmacy Claims**	**50,264,416**	**64,029,093**	**651,628,357**	**682,777,709**	**647,300,217**	**690,679,545**	**682,777,709**
27								
28	**Net Claim Payments**	**234,021,219**	**223,271,019**	**2,618,751,924**	**2,517,406,200**	**2,730,149,447**	**2,663,046,034**	**2,517,406,200**
29								
30	**Medicare Advantage Premium Payments**	**12,382,444**	**-**	**78,538,847**	**-**	**86,864,744**	**-**	**-**
31								
32	**Net Administrative Expenses**	**13,001,226**	**13,364,005**	**148,134,913**	**161,401,639**	**182,446,628**	**189,387,392**	**161,401,639**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**259,404,889**	**236,635,024**	**2,845,425,684**	**2,678,807,839**	**2,999,460,819**	**2,852,433,426**	**2,678,807,839**
35								
36	**Plan Income/(Loss)**	**(18,107,355)**	**(374,397)**	**175,070,092**	**281,240,475**	**(38,927,275)**	**83,876,185**	**281,240,475**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	976,665,395	783,862,343	783,487,948	502,247,471	755,749,494	502,247,475	502,247,471
41	**Ending Cash Balance/(Deficit)**	**958,558,040**	**783,487,946**	**958,558,040**	**783,487,946**	**716,822,219**	**586,123,660**	**783,487,946**
42								
43	Target Stabilization Reserve @ 6/30/14	239,446,206	199,728,453	239,446,206	199,728,453	239,446,206	199,728,453	188,805,465
44								
45	**Cash Balance Over/(Under) Reserve Target**	**$ 719,111,834**	**$ 583,759,493**	**$ 719,111,834**	**$ 583,759,493**	**$ 477,376,013**	**$ 386,395,207**	**$ 594,682,481**

Comments:
a. Minor differences compared to other reports are due to rounding

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended June 2014
Fiscal Year 2013-2014

#		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru June	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru June	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 2,941,097,678	$ (5,665,448)	$ 2,935,432,230	$ 2,902,567,015	$ 32,865,215	1.13%
4	Premium Refunds/Retroactive Disenrollments	(299,923)		(299,923)	(1,466,766)	1,166,843	-79.55%
5	Medicare Part D (RDS) Subsidy	11,583,652		11,583,652	6,218,762	5,364,890	86.27%
6	Medicare PDP (EGWP + Wrap) Subsidy	63,780,569		63,780,569	50,346,402	13,434,167	26.68%
7	Medicare Advantage (MA) Subsidy (Note 3)	417,565	(417,565)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**3,016,579,541**	**(6,083,013)**	**3,010,496,528**	**2,957,665,413**	**52,831,115**	**1.79%**
10							
11	**Other Revenue (Note 4)**	**3,916,235**	**(54,973)**	**3,861,262**	**2,868,131**	**993,131**	**34.63%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**3,020,495,776**	**(6,137,986)**	**3,014,357,790**	**2,960,533,544**	**53,824,246**	**1.82%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	1,967,123,567		1,967,123,567	2,082,849,230	(115,725,663)	-5.56%
18	Net Pharmacy Claims (Notes 5 and 6)	651,628,357	31,605,817	683,234,174	647,300,217	35,933,957	5.55%
19	**Net Claim Payments**	**2,618,751,924**	**31,605,817**	**2,650,357,741**	**2,730,149,447**	**(79,791,706)**	**-2.92%**
20							
21	**Medicare Advantage Premiums**	**78,538,847**		**78,538,847**	**86,864,744**	**(8,325,897)**	**-9.58%**
22							
23	**Net Administrative Expenses**	**148,134,913**		**148,134,913**	**182,446,628**	**(34,311,715)**	**-18.81%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**2,845,425,684**	**31,605,817**	**2,877,031,501**	**2,999,460,819**	**(122,429,318)**	**-4.08%**
26							
27	**Plan Income/(Loss)**	**175,070,092**	**(37,743,803)**	**137,326,289**	**(38,927,275)**	**176,253,564**	**-452.78%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	783,487,948		783,487,948	755,749,494	27,738,454	3.67%
32	**Ending Cash Balance/(Deficit)**	**958,558,040**	**(37,743,803)**	**920,814,237**	**716,822,219**	**203,992,018**	**28.46%**
33							
34	Target Stabilization Reserve @ 6/30/14	239,446,206		239,446,206	239,446,206	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 719,111,834**	**$ (37,743,803)**	**$ 681,368,031**	**$ 477,376,013**	**$ 203,992,018**	**42.73%**

Adjustment Notes:
1. Member premiums adjusted to include $10.3 million in prepaid July premiums received in June 2013.
2. Member premiums adjusted to exclude $16.0 million in prepaid July premiums received in June 2014.
3. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
4. Other revenue adjusted to exclude unbudgeted reimbursement of prior year expenditures.
5. Pharmacy claims adjusted to exclude $5.8 million in unbudgeted EGWP rebates earned last fiscal year but not received until October 2013.
6. Pharmacy claims adjusted to remove the unbudgeted portion of a rebate true-up payment that was $25.8 million more than anticipated.

Adjusted Variance Report Based on Certified (Original) Budget
Fiscal Year to Date Through June 2014

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2015 Enrollment Rules – Medicare Retirees

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Medicare Primary Enrollment

- As a reminder, at the last board meeting the Plan was in the process of discussing renewal pricing (i.e. the fully insured premium rates applicable for 2015) with the Medicare Advantage Carriers and was unable to make a recommendation regarding enrollment and contribution strategies for our Medicare Primary members.

- Renewal pricing has been finalized with the Medicare Advantage Carriers and Plan staff is now able to make a recommendation.

Medicare Primary Enrollment

Plan staff recommends a passive enrollment for existing Medicare Primary Retirees, Dependents and Surviving Dependents who have already made a Medicare Primary election.

Any new Medicare Primary Retirees will be assigned an MAPDP Base Plan and will have the opportunity to elect any of the Medicare Primary options.

Preferred Medicare Primary Enrollment Approach	
Member Type	**Open Enrollment Type**
Existing Medicare Primary Retirees, Dependents and Surviving Dependents	**Passive** - Unless they make a new election during Annual Enrollment, they will remain in the Medicare Primary Plan they had previously elected
New Medicare Primary Enrollees (New Medicare Primary Retirees or Members who will age into Medicare primacy in November, December, January)	**Active** - Member will be auto-enrolled into a Medicare Advantage Base Plan and have the option to elect any of the other three Medicare Advantage Plans or the Traditional 70/30 Plan

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

ACA Preventive Medications & Services

Board of Trustees

August 1, 2014

Updated to Include Segal Financial Impact Analysis

A Division of the Department of State Treasurer

Presentation Overview

- Federal Preventive Care Updates
- ACA Compliance
- Current ACA Preventive Medications
- Primary Breast Cancer Preventive Medication Coverage
- Guidance on Tobacco Cessation Interventions
- Current QuitlineNC Coverage
- Expanded Preventive Tobacco Cessation Interventions

Federal Preventive Care Updates

1. **Medications for Risk Reduction of Primary Breast Cancer**

In January 2014, a U.S. Department of Labor FAQ was released updating guidance concerning coverage of breast cancer preventive medications. The US Preventive Services Task Force (USPSTF) recommends providers offer to prescribe risk-reducing medications for women who are at increased risk for breast cancer and low risk for adverse side effects (i.e. "Category B" recommendation). Non-grandfathered plans must cover these medications at $0 cost share to the member beginning in January 2015.

2. **Smoking and Tobacco Cessation Therapies**

Recently, the US Departments of Labor (DOL), Health and Human Services (HHS), and Treasury jointly provided additional guidance via an FAQ to assist stakeholders in understanding, implementing and complying with the USPSTF recommendations to provide preventive coverage for tobacco cessation interventions.

Affordable Care Act (ACA) Compliance

- The Consumer-Directed Health Plan (CDHP) is a non-grandfathered plan and must comply with all ACA preventive service requirements

- The Enhanced 80/20 and Traditional 70/30 PPOs are grandfathered plans and therefore do not have to comply with all ACA preventive service requirements
  - The Board previously approved coverage of ACA preventive services at $0 member cost share under the Enhanced 80/20 Plan

Current ACA Preventive Medication List

Effective January 1, 2014, medications in the categories listed below are available at no member cost share, subject to specific age and gender requirements of the ACA, for members enrolled in the Enhanced 80/20 Plan and CDHP. All medications require a prescription.

Drug or Drug Category	Criteria
Aspirin (to prevent cardiovascular events) – Generic OTC 81mg and 325mg	Men ages 45 to 79 years and women ages 55 to 79 years
Fluoride – Generic OTC and prescription products	Children older than 6 months of age through 5 years old
Folic Acid – Generic OTC and prescription products 0.4 – 0.8 mg	Women through age 50 years
Iron Supplements – Generic OTC and prescriptions products	Children ages 6 to 12 months who are at risk for iron deficiency anemia
Smoking/Tobacco Cessation – Generic OTC patches and gum	Members ages ≥ 18 who enroll in the QuitlineNC multi-call program and do not have a have a medical exclusion
Vitamin D – Generic OTC and prescription products	Men and Women ages ≥ 65 who are at increased risk for falls
Women's Preventive Services & contraception coverage 1) Barrier contraception – i.e. caps, diaphragms 2) Hormonal contraception (generic and select brands) - oral, transdermal, intravaginal, injectable 3) Emergency contraception 4) Implantable medications 5) Intrauterine contraception 6) OTC contraceptives (with a prescription)	Women through age 50
Bowel preparation for colonoscopy screening	Men and women ages 49 to 76 years Generic and brand prescription and OTC preparations Two prescriptions per year

Proposed Primary Breast Cancer Preventive Medication Coverage

Medications Eligible for $0 Member Cost Share:

- Generic tamoxifen
- Generic raloxifene
- Brand Soltamox (tamoxifen liquid)
  - Tamoxifen liquid will be covered at $0 member cost share if the prescriber provides information that the patient meets all other criteria and cannot swallow or has difficulty swallowing tamoxifen tablets

Other Coverage Requirements:

- Coverage is subject to specific age and gender recommendations issued by the USPSTF as required by the ACA
- Prescription required

Primary Breast Cancer Preventive Coverage Review Criteria

- Women ≥ 35 years of age who:
  - do **not** have a prior history of a diagnosis of breast cancer, ductal carcinoma in situ (DCIS), or lobular carcinoma in situ (LCIS),
  - are being prescribed tamoxifen or raloxifene for the purpose of primary prevention of invasive breast cancer because the patient is deemed high risk,
  - are post-menopausal, if prescribed raloxifene (this does not apply to a woman prescribed tamoxifen).
- Providers must request a “copay review process” for coverage of medications at $0 member cost share
  - Similar to prior authorization to ensure the medication is for prevention

Cost of Primary Breast Cancer Preventive Medication Coverage

Pharmacy Cost PMPM Estimates for $0 coverage*

Estimates of Utilizing Members	Estimated Total Gross Rx Cost PMPM Impact
Estimate of eligible women for $0 cost share based on current estimates at ESI (<0.1% of women 35 years of age or greater)	<$0.01
Estimate if current eligible women for $0 becomes 1%	$0.04
Estimate if cost share for all current utilizers in ESI BOB was $0	$0.05
Estimate if all eligible women for chemoprevention were covered at $0 cost-share (15.5%[3])	$2.40

* Express Scripts cost estimates based on book of business claims data. The Segal Company is reviewing the cost estimates.

Primary Breast Cancer Preventive Medication Coverage

Plan staff recommends adding
Primary Breast Cancer Preventive Medication Coverage
outlined on slide 6 as part of the Plan's ACA preventive
medication coverage for the CDHP and Enhanced 80/20
benefit options, effective January 1, 2015.

Guidance on USPSTF Tobacco Cessation Interventions

The Departments (DOL, HHS, Treasury) will consider a group health plan to be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan covers without cost-sharing:

- Screening for tobacco use; and,
- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
  - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Current QuitlineNC Coverage, Programs & Supports

Coverage:

- **Quit Attempts** – 2 per Plan year
- **Tobacco Cessation Counseling** – 4 sessions with a Quit Coach over the phone per multi-call enrollment
- **Nicotine Replacement Therapy (NRT**) – 60 day supply of patches, gum, or combination therapy available to members enrolled in the multi-call program with option to re-enroll once per Plan year.

Cessation Programs:

- **Initial Intake Call** – information about the program & benefits of quitting.
- **One Call Program** – discuss motivation to quit & reluctance to set a quit date. Members receive a 90 day follow-up call.
- **Multi-Call Program** – 4 phone-based coaching sessions for members ready to quit within 30 days of initial intake call.

Additional Supports:

- **Quit Coach®** – unlimited one-on-one support by telephone (24 hours/day, 7 days/week)
- **Web Coaching** – access to progress trackers, exercises, information and social support at www.QuitlineNC.com
- **Quit Kit** – self-help manual and printed educational materials
- Referrals to NC Health*Smart* program services

Current QuitlineNC NRT Options

- All NRT options are free for members enrolled in the multi-call program
- NRTs are sent in two, 30 day shipments
- Eligible members may re-enroll in multi-call program to receive up to two 60-day NRT courses per Plan year

Quitline NRT Option	Shipment #1 4 weeks	Shipment #2 4 weeks
Patches only Habitrol (generic) 7, 14, 21 mg	$48 for 28 patches	$48 for 28 patches
Gum only Generic 2 mg, 4 mg (110 pieces per box)	$90 for 3 boxes (330 pieces)	$30 for 1 box (110 pieces)
Combo NRT (patch + gum)	$108 for 28 patches + 1 box of gum	$48 for 28 patches (no gum)

Proposed Changes to Tobacco Cessation Coverage

QuitlineNC Services

CDHP, Enhanced 80/20 and Traditional 70/30 Plans:

- Extend each QuitlineNC treatment time period to 90 days of therapy and counseling
- Add lozenges to the QuitlineNC nicotine replacement therapy offering

Tobacco Cessation Medications

CDHP and Enhanced 80/20 Plans:

- Add coverage of prescription generic bupropion sustained-release 150mg and brand varenicline (Chantix®) to ACA preventive medication coverage
- Limit Chantix coverage to a 6 month supply in a 12 month period
- Limit $0 member cost share for all tobacco cessation products (prescription and OTC) to members ≥ 18 years of age

Cost of Expanded Tobacco Cessation Coverage

- Adding nicotine replacement lozenges to the QuitlineNC offering is estimated to cost an additional $16,728 per year.*
- Using Express Scripts book of business claims data, the impact on pharmacy costs for covering generic bupropion is <$0.01 PMPM and approximately $0.10 PMPM for the coverage of brand Chantix.^

* Cost estimate based on 1% QuitlineNC utilization

^ Cost estimates are being reviewed by The Segal Company

Preventive Tobacco Cessation Coverage

Plan staff recommends expanding
Preventive Tobacco Cessation Coverage
as outlined on slide 13, effective January 1, 2015.

Segal Financial Impact Analysis

Costs of Additional ACA Preventive Medications

	CY 2015	CY 2016	CY 2017	CY 2018
Risk Reduction of Breast Cancer	$124,000	$229,000	$246,000	$263,000
Smoking Cessation	$568,000	$1,047,000	$1,120,000	$1,199,000
Total	**$692,000**	**$1,276,000**	**$1,366,000**	**$1,462,000**

Notes

- Assumes 100% coverage of the new medications begins January 2015 for members in the CDHP and Enhanced 80/20 Plans
- Consistent with current forecast assumptions, assumes 100% coverage of preventive services is extended to the Traditional 70/30 Plan beginning January 2016, but this benefit change is still *subject to Board approval*
- Cost estimates may change depending on annual trend assumption

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES

Update on Potential Benefit Option for Newly Eligibles

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Planning for Statutory Change
- Employer Workgroup
- Workgroup Recommendations for Administration
- Implementation Status
- Appendix

Planning for a Change to the Eligibility Statutes

- Legislation to create a new eligibility category for nonpermanent full-time employees to comply with the Affordable Care Act (ACA) is pending in the General Assembly
- Given the interest in establishing a lower cost alternative health benefit plan for nonpermanent full-time employees, the Plan expects legislation to be enacted that:
  - Directs the Treasurer and Board to offer a health benefit coverage option for these "newly eligible" employees that provides minimum essential coverage at no greater than the ACA "Bronze" level and that minimizes the employer contribution in an administratively feasible manner

Workgroup Formed

- The Plan formed an informal workgroup to build consensus on an administrative approach to providing coverage for newly eligibles
- The workgroup consists of representatives from:
  - Office of State Human Resources (OSHR)
  - Department of Public Instruction (DPI)
  - University of North Carolina General Administration (UNC-GA)
  - NC Community College System Office
  - Local Education Agencies
    - Charlotte-Mecklenburg Schools
    - Guildford County Schools
    - Orange County Schools
    - Wake County Public School System

Workgroup Recommendations: Rate Structure

Three options for administering the assignment of the employer and employee share of the monthly premium were discussed:

1. **Pay Bands** – Member enrolled by the HBR into one of four pay bands, each with predetermined employer and employee premium amounts – income based approach for employee premium
2. **Single Rate with Employer and Employee Shares Defined** – All employees charged the same premium rate; the employer share is also fixed – same approach used to assign premiums for CDHP, 80/20 and 70/30 plan options for permanent full-time employees
3. **Single Total Premium Rate** – Each employing unit determines what rate to charge the employee – allows employing units to minimize employer contribution

Workgroup determined that Option 2, Single Rate with Employer and Employee Shares Defined, is the most administratively feasible rate structure

Workgroup Recommendations: Employee Premium Billing

Two options for billing and collection of employee premiums were discussed:

1. **Direct Billing** – Member receives a monthly bill for the employee share of the premium which must be remitted on time to avoid termination
2. **Group Billing** – Employing unit receives a monthly bill for the total premium (employer and employee shares combined) and is responsible for collecting the employee's share of the premium; late or retroactive terminations for delinquent employee accounts will not be accepted

Workgroup determined that Option 1, Direct Billing for the employee share, is the most administratively feasible billing methodology

- By direct billing the member, instead of utilizing payroll deduction, the employing units do not have to establish a premium collection process for payroll periods for which the member does not receive a paycheck
- The Plan may be able to offer a choice of billing options at the group level – billing for all employees in a group must be the same

Workgroup Comments: Minimum Value Plan

The Plan did not request a recommendation, but did solicit feedback on providing a “minimum value plan” for newly eligibles

Benefit Design	Individual Coverage	Family Coverage
Individual Deductible	$5000	$10,000
Out of Pocket Maximum	$6,450	$12,900
Coinsurance	50%	50%
Preventive Medical	Covered at 100%	
Preventive Pharmacy	Covered at 100%	

Meets ACA minimum value standard
Eligible for a Health Savings Account (HSA), which will allow the employee to make 2015 tax-exempt contributions of up to $3,350 ($6,650 for family coverage) to an account that can be used to pay eligible medical expenses

Workgroup is supportive of the offering and thinks other employees might be interested in the option as well

Implementation Status

Enrollment and Billing Functionality In-progress

- Online Enrollment
- Group Billing
- Member Direct Billing
- Data Transfers

Next Steps

- Await Legislative Action
- Board Approval of Benefit Design and Premium Rates
- Benefits Build
- Testing
- Communications Plan
- Annual Enrollment

Appendix

ACA Requirements – Who is Eligible for Coverage?

- The Affordable Care Act (ACA) and section 4980H of the Internal Revenue Code (the Code) prescribe updated definitions of full-time employees and requirements to determine which employees are required to be offered employer-sponsored health care
- Employees are determined to be full-time, and thus required to be offered employer-sponsored health care, if they are reasonably expected to work 30 hours per week
  - Employers have flexibility in their measurement and stability periods on determining eligibility
  - This includes all non-permanent full-time employees. Non-permanent full-time employees are currently not offered coverage through the State Health Plan
- Employers are penalized for not meeting Employer Responsibility requirements

ACA Requirements – What are the Coverage Rules?

To avoid Employer Shared Responsibility penalties, full-time employees must have access to a plan that meets the definition of Minimum Essential Coverage:

- At least **Minimum Actuarial Value:** Provides at least a value of 60% of the cost of services (Bronze level on the Exchange)
  - The Plan had Segal design a minimum value high deductible health plan and a slightly more generous Bronze level plan

- **Affordable:** Costs an employee no more than 9.5% of gross taxable wages for self-only coverage
  - An employer contribution *will be needed* for low-wage employees in order to maintain affordability and ensure the avoidance of penalties
  - A decision is needed on the approach to set the employee and employer contributions

Potential Alternate Plan Designs Compared to Traditional 70/30

Plan Design Components	Traditional 70/30 Plan	Minimum Creditable Coverage (MCC)	Bronze Level Plan
		(60% Actuarial Value)	(66% Actuarial Value)
Deductible	$933	$5,000	$1,400
Health Saving Account Compatible	No	Yes	Yes
Coinsurance	70%	50%	50%
Medical Coinsurance Maximum	$3,793	N/A	N/A
Out-of-Pocket Maximum	N/A	$6,450	$6,450
Medical Copays			
Preventive Care	$35 or $81	$0	$0
Primary Care Provider	$35	Deductible, then coinsurance	Deductible, then coinsurance
Specialist Visit	$81	Deductible, then coinsurance	Deductible, then coinsurance
Inpatient Hospital	$291	Deductible, then coinsurance	Deductible, then coinsurance
Emergency Room Services	$291	Deductible, then coinsurance	Deductible, then coinsurance
Pharmacy Copays			
Generic	$12	Deductible, then coinsurance	Deductible, then coinsurance
Preferred Brand Drugs	$40	Deductible, then coinsurance	Deductible, then coinsurance
Non-Preferred Brand Drugs	$64	Deductible, then coinsurance	Deductible, then coinsurance
Specialty High-Cost Drugs	75% coinsurance	Deductible, then coinsurance	Deductible, then coinsurance
Out-of-Pocket Maximum	$2,500	Included in total Out-of-Pocket	Included in total Out-of-Pocket

Setting Employee and Employer Contributions

Statutory language will likely provide guidance on the premium contribution structure; the Plan is exploring three options:

- Option 1 – Pay Bands
- Option 2 – Single Rate with Employer & Employee Shares Defined
- Option 3 – Single Total Premium Rate

Note: Regardless of the option selected for determining the employee contribution, the employee will be responsible for the full premium cost of dependent coverage

Option 1 – Pay Bands

Establish several (2-5) pay bands with employee contributions equal to 9.5% of the minimum salary level of each pay band; employer pays the remaining amount

- Pros: Administratively feasible approach to minimizing employer contribution
- Cons: Fairness issue – employees at the lower end of the pay bands contribute a higher percentage of their salary for health benefit coverage than employees at the upper end of the pay bands; HBRs may have trouble determining correct salary band for each employee

Option 2 – Single Rate with Employer & Employee Shares Defined

Establish one employee contribution rate equal to 9.5% of the federal poverty level (approximately $90 per month); employer pays the remaining amount (approximately $110 to $160 per month)

- Pros: Simplified premium structure and administration; consistent with premium structure for CDHP, 80/20 and 70/30 plan
- Cons: Higher employer contribution

Option 3 – Single Total Premium Rate

Plan bills employing unit for total premium amount; employing unit determines employee contribution equal to 9.5% of salary, not to exceed total premium amount; employer pays the remaining amount

- Pros: Minimizes employer contribution
- Cons: Administratively difficult; the Plan cannot assist employing units with the determination, billing or collection of the employee premium

Segmentation Pilot

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Current IHM Communication Efforts

- **Member Focus Newsletter**
  - 250,085 members currently subscribe to this newsletter, with an average open rate of 17%.

- **Health Benefit Representative (HBR) Update Newsletter**
  - 1,705 HBRs currently subscribe with an average open rate of 43%.

- **Mailers and Fliers**
  - 8 direct mailers (postcards), touching all or segments of the population
  - Various fliers used to promote benefits and programs

Currently we are unable to correlate any outcome to these methods of communication (fluctuations in call volume seem random).

Opportunity for Improvement

- We have the opportunity through ActiveHealth Management (AHM) to pilot a segmentation and communication initiative among the Active and Non-Medicare Retiree membership.

- This opportunity will result in information that can assist the Plan in the development of a communication and marketing strategy that aims to elicit a higher response and participation by our members.

Segmentation Pilot

August 1, 2014
Kim Wiese
SVP Product Marketing and Strategy

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Importance of segmentation

What it does:

- Classifies members into **groups** with common needs, desires and behaviors
- Identifies a manageable number of homogenous member **segments**
- Allows the entire member population to be broken down into **smaller** and more **relevant segments**
- Enables **prediction** of likely responses and behaviors
- Enables **communication** and product **testing** to optimize results for a particular segment

Why it matters…

- Provides deeper **understanding** of member **needs** and **behaviors** for each member segment, which enables personalization
- Allows more appropriate **resources**, using techniques aligned to specific member segments, to drive behavior change and **improved results**

Market segmentation overview

The following process allowed ActiveHealth to segment its population into groups with uniform behaviors, attitudes and lifestyles to optimize product/service effectiveness

Gather Internal Data

- Gather demographics, health history, risk assessments, health attitudes, interaction data, ActiveHealth CareEngine® analytics
- Organize and aggregate at the Member, Activity and Condition level

Gather External Data

- Gather generally available, non-specific information about household behaviors and lifestyles

Combine

Prepare Data

- Determine health attitudes, behaviors and lifestyles
- Put demographics and behaviors in context
- Convert all data into numeric form for statistical analysis

Segment

- Apply cluster analysis algorithms (e.g. K-Means, CART) to determine segments

Develop Personas

- Analyze all Segment characteristics
- Develop representative example Persona Profiles for each Segment
- Optimize products/ services for each Segment

ActiveHealth MANAGEMENT

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Segmentation will enable enhanced support

Growing opportunity to support **Self-Directed** as we optimize products

High opportunity to support **Validators**

RESPONSIVENESS TO CARE MANAGERS

Ignoring outreach — Engaging

PARTICIPATION WITH OUR PRODUCTS / SERVICES

Actively participating

Not actively participating

SELF-DIRECTED

Make health decisions on their own; seek best care

Information
Value
Speed
Control
Simplicity

VALIDATORS

Interested in health; seek advice on complex decisions

Advice
Information
Value
Reassurance
Trusted relationship

Interaction needs

AVOIDERS

Spend little time thinking about health; worry free

Simplicity

TIME-CONSTRAINED

Little time available to deal with health; interested, but want support from others

Advice
Good service
Trusted relationship

Source: Knowledgent Cross-Industry Framework Applied To ActiveHealth's Business

Lower opportunity to support **Avoiders**; knowing helps us refine and re-allocate efforts

Growing opportunity to support **Time-Constrained** as we optimize products

ActiveHealth MANAGEMENT

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Successful pilot test results!

Member Engagement

- Significant lift in member engagement

87%

in engagement

Ongoing Impact:

- Identified areas of operational efficiency, which will fund care management redesign and engagement initiatives (more personalized outreach with higher satisfaction)

High tech — High touch

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2014 roll out plan

After completion of a **highly successful segmentation test,** we will continue to test and then roll out segmentation and a new communication engine later this year

- Internal, **cross-functional team** established for roll out
- Bridged approach for **roll out and support**
- Working with **third party data** provider on information purchase
- Finalizing launch **business requirements**
- Preparing to launch the **Communication Engine,** which is a major inter-dependency

Segmentation and Personalization Approach

Channel Optimization

Message Optimization

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2014 segment testing scope – North Carolina

Timing	Details	Benefit
Phase 1 *Based on the size of the previous pilot phases ActiveHealth anticipates ~4,000-6,000 Plan members will partake*	• Conduct **channel & message testing** with newly identified DM and LC members **Channel Test:** • Control Group A: Automated calls • Test Group B: Emails • Test Group C: Live CSA calls **Message Test:** • Control Group A: Standard intro letters • Test Group B: Optimized intro letters	• Validates previous findings on pilot tests • Larger sample size will help validate assumptions across broader population
Phase 2 *Based on the size of the previous pilot phases ActiveHealth anticipates ~2,000-3,000 Plan members will partake*	• Conduct **segment specific message testing** with newly identified DM members **Intro Email/Call:** • Control Group A: Control intro Email (auto call when Email not available) • Test Group B: Segment specific Emails • Test Group C: Segment specific auto call **Intro Letter:** • Control Group A: Standard intro letters • Test Group B: **Segment specific** letters	• Validates findings on segment attributes and key messages • Will only focus on DM (those segments **with conditions**)

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Phase 2 segment specific creative test

Determine impact of **new, segment-specific letters (vs. control letter)**

"Control" – Standard Letter

PO Box 221138
Chantilly, VA 20153-1138

<PRINT DATE>

<PT FIRST NAME> <PT LAST NAME>
<PT ADD 1>
<PT ADD 2>
<PT CITY>, <PT STATE> <PT ZIP>

Dear <PT FIRST NAME> <PT LAST NAME>,

Welcome to Active Lifestyle Coaching

You've got a great wellness program ...s, available through ActiveHealth. You have resources at your fingertips that can help you take control of your health. And, it's personal, confidential and private.

Do you want to get your eating habits back on track? Or maybe you're ready to quit smoking? Work one-on-one over the phone with a professional health coach to achieve the goals you want to. Your coach can help you:

- Reach your best health goals by losing weight, eating healthier, managing stress, quitting tobacco and more
- Develop – and stick to – healthier lifestyle habits that work for you
- Build a personalized plan to keep you healthier for years to come

How we work together is up to you

You can schedule regular phone calls with your health coach. Or you can call when you have questions or want tips. Whatever works for you. We can meet on your terms because, after all, they're your goals.

You can also try our online coaching, tools and resources. They make it easy and fun to improve your health. Just go to **www.MyActiveHealth.com**

Take a first step toward a healthier lifestyle.
Just give us a call at (888)-227-6598.

Learn more about ... cluding how you can earn rewards on

Sincerely,

Your Health Advocate Team

"Test" – Segment Optimized Letter

ActiveHealth MANAGEMENT. P.O. Box 221138 Chantilly, VA 20153-1138

<PRINT DATE>

<PT FIRST NAME> <PT LAST NAME>
<PT ADD 1>
<PT ADD 2>
<PT CITY>, <PT STATE> <PT ZIP>

To start taking charge of your health, visit MyActiveHealth today!
MyActiveHealth.com/

Dear <PT FIRST NAME> <PT LAST NAME>,

Do you want to look better, feel better, live longer or reduce your risk factors for illness? Maybe you want to quit smoking or lose a few pounds. No matter what your goal, the most important thing is that you take the first step to make it happen. Now that's a lot easier thanks to the Healthmatters program.

24/7 Lifestyle Coaching to help you meet your goals.
If you're ready to make a change, ActiveHealth has resources that can help. Our online health coaching program takes into account your unique challenges. For example, some of our members are dealing with stress. Others need help quitting smoking. We focus on what matters to you. So you can focus on small things that make a big difference in your health.

This support is available to you right now, at home or work or on the go. Anywhere you have internet access. This program will provide:

- A tailored plan based on your specific needs.
- Fun tools and expert tips to help you meet your goals.
- Emails to help you stay on track.

If you're ready to begin the journey to better health, you don't have to do it alone. Best of all, this program is available at no cost to you. It's also completely confidential.

To get started, visit MyActiveHealth.com.
Then, choose "online health coaching" and select which program fits your personal goals.

Sincerely,

Your Health Advocate Team

P.S. To learn more about this program,

Messaging will be tailored in partnership with NC and based on segment insights

Segment appropriate language and tone

Work with NC to select segment appropriate image

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2014 Proposed Schedule

W 1 | W 2 | W 3 | W 4 | W 5 | W 6 | W 7 | W 8 | W 9 | W 10 | W 11 | W 12 | W 13 | W 14 | W 15 | W 16 | W 17 | W 18 | W 19 | W 20

Pre-Requisites
- Pre-Reqs

ID & Design Creative
- ID
- Design

Channel & Message Testing

Configure ActiveAdvice
- Config

Segment Specific Message Testing

Manually Process Cycle
- Manually Process Month_1 Cycle
- Manually Process Month_2 Cycle

Extract Cycle Results
- Extract
- Extract

Produce Results By Segment
- Results
- Results

Check-Point Re. Cycle y+2
- Check-Point
- Check-Point

Multipronged Pilot Initiative to Improve Member Health

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Multipronged Pilot Initiative

- Overview
- Target Area
- Project Plan & Timeline
- Expectations
- Evaluation

Multipronged Initiative: Overview

The Integrated Health Management (IHM) team proposes a two-year targeted pilot initiative for three eastern counties, utilizing a multipronged approach.

- Engage and support providers in delivering a higher level of care to our members
- Develop and strengthen wellness networks and worksite wellness initiatives
- Connect local leadership and resources to worksites
- Engage and empower members in their healthcare

Target counties: **Greene, Jones, and Lenoir** (Eastern NC)

Why Greene, Jones, and Lenoir Counties?

Major Chronic Conditions

Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Hypertension

Greene Lenoir Jones

South Carolina

Big 6 condition Prevalence
- 9.5%
- 11.9%
- 14.2%
- 16.6%
- 19.0%
- 21.3%

Source: ActiveHealth Management, Heat Maps, 2014

Why Greene, Jones, and Lenoir Counties?

Major Chronic Conditions

Disease Burden = Prevalence x Severity

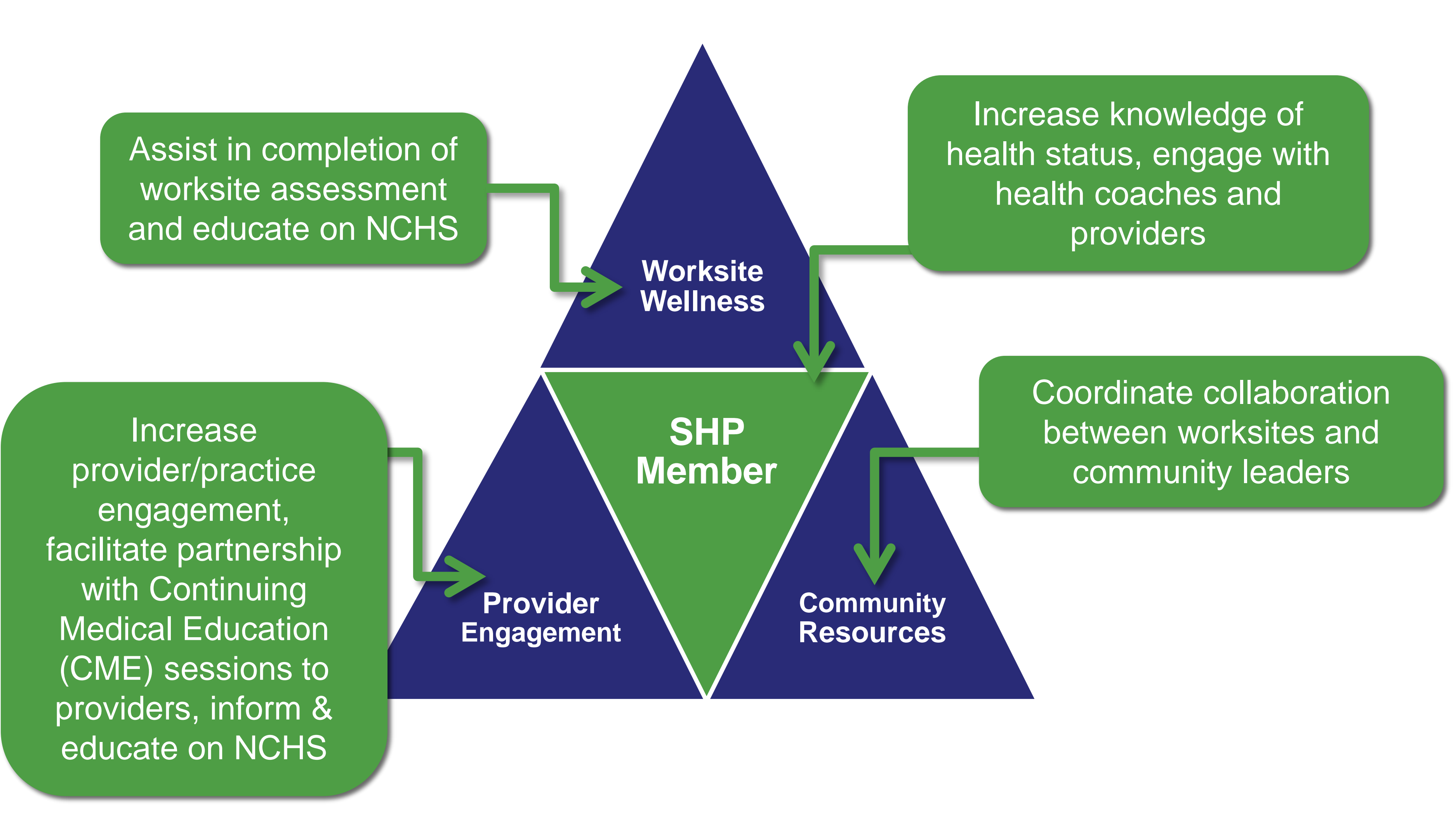
Source: ActiveHealth Management, Heat Maps, 2014

Why Greene, Jones, and Lenoir Counties?

County	Jan. 2014 Member Count	Community College	School System	Agencies	Disease Prevalence: Diabetes	Disease Prevalence: Asthma/ COPD	Disease Prevalence: Cardiovascular Disease
Greene	1,558	Lenoir CC	Greene County Schools	Greene Correctional	13.4%	8.2%	4.6%
Jones	692	Lenoir CC	Jones County Schools	Unknown	11.6%	8.7%	5.7%
Lenoir	5,968	Lenoir CC	Lenoir County Public Schools; Charter schools	Caswell Center	11.9%	8.0%	6.2%
All State Health Plan Members					**8.25%**	**6.19%**	**3.37%**

Source: ActiveHealth Management

Multipronged Approach



Multipronged Initiative: Project Plan and 2 Year Timeline

Preliminary Phase: *July-Dec 2014*

Environmental assessment, engagement with wellness leaders & HBRs at worksites, participate in community meetings, provider focus groups, conduct NC Health*Smart* (NCHS) webinars and presentations to build awareness

Phase 1: *Jan-March 2015*

Train wellness leaders to deliver NCHS presentations; assess worksites and develop worksite wellness initiatives (organize committees and help build wellness programs); engage providers through CMEs and provider meetings (support awareness of NCHS resources and referrals)

Phase 2: *April-July 2015*

Increase member awareness of health status through biometric screenings (ensure validated screening results for Health Assessment); connect to NCHS and community resources to support healthy lifestyle

Phase 3: *June 2015-July 2016*

Engage members in care of chronic conditions, build on-site coaching for worksites with wellness programs, continue provider engagement and awareness

Phase 4: *July-Sept 2016*

Members participate in follow-up biometric screenings and outcomes evaluation, ensure worksites have resources to maintain sustainable worksite wellness programs

Multipronged Initiative: Expectations

- **Support member awareness of NC Health*Smart* (NCHS) services to create more proactive members**
  - Offer multiple NCHS presentations; Train the Trainer on NCHS presentations
  - Utilization of Health Coaches
  - Health status awareness through biometric screenings

- **Develop and strengthen wellness networks and worksite wellness programs**
  - Offer Prevention Partners assessment and assistance to active worksite wellness programs
  - Outreach to worksites without current programs to facilitate creation of worksite wellness
    - Use CDC Scorecard, Worksite Wellness Toolkit (revised), and assistance of SHP Wellness Coordinators

- **Engage local providers to deliver a higher level of care to SHP members**
  - Partner with CCME/AHEC to offer CME opportunities to providers on Diabetes and Asthma, *including information on NCHS at each session*
  - Support provider meetings in Lenoir, Greene and Jones counties to create Provider Champions
  - Encourage provider meetings between AHM, SHP, and local providers to determine how best SHP can engage their individual practices

Multipronged Initiative: Evaluation

Utilization

- Wellness Programs
  - Number of wellness champions
  - Established wellness programs
- NCHS resources
  - Health Assessment completion
  - Engagement in DM/CM/ALC
  - Participation in on-site coaching sessions

Population Measures

- Chronic disease management based on medical claims
  - Heart disease (hypertension, CAH, CHF, stroke)
  - Diabetes/Prediabetes
  - Asthma/COPD

Utilization patterns

- PCP visits
- ER and inpatient hospital admissions/readmissions/avoidable admissions
- Medication adherence based on refills

Annual Enrollment Outreach Plan

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Annual Enrollment Communications-*Actives/Non-Medicare Retirees*

- Decision Guide (Sept)
- Reminder Postcard (Oct)
- Webinars (Sept-Oct)
- SHP Website

Annual Enrollment Communications-*Medicare Retirees*

- Outreach Meeting Invite Mailer (Aug)
- Decision Guide (Sept)
- Reminder Postcard (Oct)
- SHP Website
- Outreach Meetings

Annual Enrollment – *Medicare Outreach Meetings*

- 72 meetings in 42 counties have been scheduled
- SHP, Humana, UHC and BCBSNC will present at each meeting
- Representatives from SilverSneakers will be in attendance

Annual Enrollment: Call Center

Aon Hewitt will be supplementing the Benefitfocus Call Center by handling Retiree enrollment calls during Annual Enrollment (AE).

- **Enrollment Calls** – Members will continue to call the same number as they have always called for enrollment.
- **Call Prompt** – A call prompt will be added to the beginning of the call advising members to press a number for Retiree Annual Enrollment assistance.
- **Routing** – Members who select the Retiree Annual Enrollment assistance option will be routed to the Aon Hewitt Call Center
- **Enrollment** – Aon Hewitt will facilitate the call and enter the enrollment into eEnroll, the Benefitfocus enrollment tool.
- **Misrouted Calls** – Undoubtedly, some active members will select the Retiree Annual Enrollment option in error and end up in the Aon Hewitt Center and some Retirees will end up in the Benefitfocus Call Center. No matter who takes the enrollment call, it will be handled by the representative who answers.
- **Post Annual Enrollment –** Benefitfocus will resume taking all Retiree calls post Annual Enrollment.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Other Member Outreach Initiatives

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Pre-65 Campaign Update

Pre-65 Outreach Campaign Update

- Beginning in May, the Plan launched a campaign targeted at members turning 65 in the upcoming year to educate them on their health plan options.
- Educational materials were created to complement the meetings and assist members in understanding their options as they relate to health plan coverage and their retirement date.
- Overall these meetings were very well received by members.
- Health Benefit Representatives were also invited to attend and appreciated the information, which will assist them with their retiring employees.

Pre-65 Outreach Session Results

Results

- 41 Meetings were held in16 counties across the state
- 1,065 Members attended

Membership Satisfaction Survey

Membership Satisfaction Survey Underway

- Survey will remain open from July 14 to August 29, 2014
- Postcards were sent to members inviting them to participate

Let us know how we're doing

Your opinion matters – and so does your satisfaction with the North Carolina State Health Plan. That's why we're asking you to let us know about your experience with the Plan. As an active or retired member, both you and your covered spouse (if applicable) are welcome to participate in our quick, online survey.

Taking the survey is fast and easy:

- Go to *www.shpnc.org* by August 29, 2014
- Click on the survey link
- Take the survey

Thank you in advance for your valuable feedbac
It helps us learn what's working well and what m
need improvement to ensure an excellent meml
experience for you and your family.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

North Carolina State Health Plan
100 Benefitfocus Way
Charleston, SC 29492

Share your experience with us

Take a quick survey of the State Health Plan, and help us ensure the best member experience for you and your family.

Be sure to take the survey by August 29, 2014

Go to *www.shpnc.org* now

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Contract with NC Hospital Foundation for ADT Data Request for Approval

Board of Trustees Meeting

August 1, 2014

A Division of the Department of State Treasurer

Contract Approval Required by Statute

North Carolina General Statutes §135-48.22 and §135-48.33(a) require that the BOT approve all Plan contracts with a value over $500,000.

The cost of this contract over five years is $719,020.

This contract is exempt from Department of Administration Purchase & Contract rules pursuant to §135-48.34 as a contract for services related to the implementation of an optional program (population health management).

North Carolina Hospital Foundation

- The North Carolina Hospital Foundation (Foundation) is a 501(c)(3) nonprofit foundation affiliated with the North Carolina Hospital Association.

- The Foundation through a contract with the North Carolina Division of Public Health and a subcontract with Truven Health Care Analytics, Inc. administers the North Carolina Hospital Emergency Surveillance System Investigative Monitoring Capability (NCHESS-IMC) to capture real-time clinical data from 61 hospital information systems.

- As a result, the Foundation is uniquely positioned to provide the Plan with this real-time admission, discharge, and transfer (ADT) data.

Key Contract Deliverables

- Engage all 61 Hospitals to get permission to share ADT data with the Plan. Hospital participation is voluntary; if a hospital agrees to share the data the Foundation will contract directly with the hospital for the release of the data to the Plan.
- Facilitate the collection and delivery of the ADT data from the participating hospitals three times a day to the Plan's population health management vendor. A secure file transfer protocol will be used for the transfer.
- The Foundation will notify the Plan of any issues regarding data integrity or accuracy and work with the Plan and vendor partners to address those issues.

Data Elements

a. State Employee Health Plan Group Number
b. Hospital Patient Identification Number
c. Patient Name
d. Patient Date of Birth (DOB)
e. Patient Gender
f. Patient Address
g. Patient Phone
h. Emergency Department (ED)/Inpatient Facility
i. Date of Admission (DOA)
j. Chief Complaint
k. International Classification of Diseases (ICD) 9 and Current Procedural Terminology (CPT) Codes
l. ED Disposition
m. Discharge Date
n. Caregiver Names (Attending, Consulting and Admitting)

Use of the Data

- Data will be used by the Plan's population health management vendor, ActiveHealth Management, to:
  - Develop a care coordination program.
  - Identify high priority members who will benefit from participation in the care coordination program.
  - Deliver care transition services including medication reconciliation, follow up appointments and visits.

Population Health Management Strategy

Receipt of this data can assist the Plan with its goal to reduce avoidable hospitalizations, hospital readmissions and emergency department utilization:

- In 2013, the hospital admission rate for active members was 54/1000 with an all cause readmission rate of 7.9/1000. The average cost of admission was $14,806.
- The hospital admission rate for Pre-Medicare Retirees was 69/1000 with an all cause readmission rate of 15.7/1000. The average cost of admission was $22,782.
- Emergency department costs represent $146 million in annual medical costs (4.2% of spend)
- The data will provide useful information to address:
  a. Transition of care
  b. Medication Therapy Management (MTM)/medication reconciliation/medication adherence

Estimated Timeline

August 2014

- SHP and NCHF to execute contract for data sharing
- Amend Contract with Active Health Management

October 2014

- Active Health Management to complete system changes
- NCHF to engage Hospitals to participate
- Data testing and transfer will begin

December 2014

- NCHF will be responsible for having hospital participation agreements executed in all 61 hospitals
- Development of care coordination program complete

2015

- Full implementation complete
- The data will be delivered by NCHF contractor ‘Truven Health Analytics’ to Active Health Management three times daily

Recommendation

Plan staff recommends approval of the Contract with the North Carolina Hospital Foundation for the real-time transmission of admission, discharge and transfer data.

Board of Trustees
of the
State Health Plan for Teachers and State Employees

Strategic Plan
2014 – 2018

August 1, 2014
DRAFT

Adopted mm/dd/yyyy: ______________________________
Janet Cowell, Chair

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EXECUTIVE SUMMARY

The State Health Plan for Teachers and State Employees (Plan) was created by statute to make available comprehensive health benefits for eligible teachers, employees, retirees and their eligible dependents. The Plan is governed by the State Treasurer, Board of Trustees (Board) and the Executive Administrator, who carry out their duties and responsibilities as fiduciaries for the Plan. The Board is responsible, by statutory mandate, for developing and maintaining a strategic plan for the Plan. This document outlines the strategic plan for the years of 2014 through 2018.

The strategic plan is organized by first identifying the Plan's mission, vision and values followed by "guiding principles" that describe the intent and motivation behind the Plan's actions. Next the Board has identified three strategic priorities for 2014-2018: 1) Improve members' health; 2) Improve members' experience; and 3) Ensure a financially stable State Health Plan. A description of what each means, what will be done, and why it is important, is also included. Specific initiatives designed to achieve each strategic priority are then identified and described again in terms of what each means, what will be done, and why it is important. Finally, a roadmap is provided that identifies major projects and programs within each initiative along with key decision points regarding contracts or benefits, launch dates, and an indication of the magnitude relative to members impacted or resources needed.

This strategic plan is designed to align the mission and vision of the State Health Plan with the programs and services provided to its members, and along with the values expressed, will serve as a guide over the period identified. Specific projects and programs are expected to be modified on a frequent basis with the priorities, initiatives and measures being revisited on an annual basis as agreed upon by the Board.

Ongoing performance monitoring, detailed project plans and other progress updates will be provided on a regularly scheduled or as needed basis. Background information, including environmental scans and other supporting analyses and conclusions used by the Board in the development of this strategic plan are available on the Plan's website at www.shpnc.org under the Board of Trustees quick link.

MISSION

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

VISION

Our vision is to be a health plan that is a leader in North Carolina in providing access to cost-effective, quality health care and wellness programs on behalf of our membership.

VALUES

Customer Focus – *Keeping the member at the forefront of our actions*

Collaboration – *Partnering with individuals and other stakeholders on behalf of our members*

Transparency – *Acting in an open manner with the highest possible degree of integrity in all we do*

Quality – *Striving for the best quality of care and service for our members*

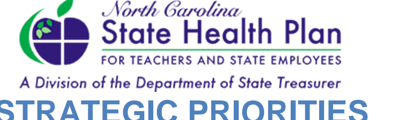
STRATEGIC PLAN GUIDING PRINCIPLES

The following guiding principles were used in developing the strategic priorities and measures of success for the State Health Plan's strategic plan:

1. The State Health Plan's **Mission Statement** will serve as the primary guide in the development of a strategic plan.

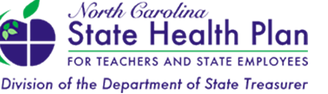
   "Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being."

2. It is the intent of the Board and Plan leadership team to ensure the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the Board and Plan leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore the Board and Plan leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.
4. The Board and Plan leadership team recognize the responsibility to work to ensure that members have **access to quality care** and that their **patient experience is continuously improved**.
5. Given the Plan's responsibility to serve members across the state, the Board and Plan leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**. Access includes addressing issues such as distance to providers, cost and length of time to schedule an appointment.
6. There needs to continue to be a **sense of urgency** to ensure the Plan remains financially stable to fulfill the mission of improving the health and health care of its members. That said, the Board and Plan leadership team acknowledge that the ability to make operational changes requires time and resources. Therefore, it is prudent to have **a reasonable period of stabilization** to manage recent member and operational impacts and to have time to measure the results of recent changes. Continuous measurement and monitoring will be an integral part of the strategic planning process.
7. The Board and Plan leadership team recognize the opportunity to develop benefit offerings and programs that will require longer time horizons to determine measurable results. Therefore, it is the intent of the Board and Plan leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the Board and Plan leadership team to effectively manage premiums that members are required to pay for coverage and for out-of-pocket health care expenses. The Board and Plan leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of health care services and improving the health of plan members. Ongoing communication and education will be critical.
9. The Board and Plan leadership team acknowledge that there will be a dependency on the **support of the North Carolina General Assembly** to fund or operationally execute on the strategic plan. The Board and Plan leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the Plan.
10. Given the dependency on 3rd party vendors and business partners, the Plan, working in the best interests of the Plan members and State of North Carolina, will take a **partnership approach** with these stakeholders in developing and executing on the strategic plan. This will include utilizing their areas of expertise and information to guide the decisions and actions of the Board and Plan leadership team.
11. The Board and Plan leadership team recognize their fiduciary responsibility first and foremost to the members of the Plan but also to the State of North Carolina and its citizens.
12. It is the intent of the Board and Plan leadership team to act in a manner that is in **the best interests of all members** of the Plan and actively work toward **consensus** that will enable the fulfillment of the mission of the Plan.



STRATEGIC PRIORITIES

Priority	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	Population health management is a model for managing all aspects of member health from wellness to chronic disease with a focus both on engaging members in their health and improving the quality and coordination of care within the health care system. The goal is maintaining or improving the health of members and lowering medical claims cost for members and the Plan.	• Maintain or improve member health as appropriate including the support of members with chronic conditions • Engage health care providers in improving the quality and coordination of care • Identify and address gaps in access to quality care or in the care itself • Promote a culture of wellness	51% of members have at least one chronic condition and account for 76% of claims expenditures. Duplication of services and the provision of services in higher cost settings significantly contribute to the cost of care. Better coordination of care and better health of the population can improve member well-being and lower costs for both members and the Plan. In addition, offering programs and products that attract membership for all stages of health ensures a more stable Plan.
Improve Members' Experience	The member experience includes the relationship members have with the Plan including enrollment, access to information, benefit designs, and affordability of coverage; services and programs provided by the Plan and its vendor partners; and access to providers and quality care through effective relationships with the Plan's network providers. The Plan also seeks to foster and improve the direct relationship between the member and the provider including the provider's practice and staff.	• Improve communication with members about benefit design, enrollment, and eligibility to promote health literacy • Increase transparency of the cost of care and the quality of network providers • Provide reliable, quality services for enrollment, claims processing, and population health management • Address member concerns regarding Plan operations, benefit design, coverage, and costs • Develop partnerships and benefit designs that improve members' experience with providers and practices	Members who are informed and satisfied with their service experience are more likely to engage with the Plan and participate in benefit designs and programs aimed at improving their health, leading to improved health and well-being for the member and lower health care costs for the both the Plan and the member.
Ensure a Financially Stable State Health Plan	The Plan must address the cost of health care, the delivery of health care, and the utilization of benefits in order to minimize State and member premium contributions, provide a cost-effective and sustainable benefit and optimize the benefits offered to members within the financial resources available.	• Manage the cost of medical claims • Manage the cost of pharmacy claims with a specific focus on specialty pharmacy management • Encourage members to use benefits appropriately and to be informed consumers of medical services. • Develop programs focused on fraud, waste, abuse and overuse • Collaborate with the General Assembly and Office of State Budget and Management to help ensure predictable funding for health benefits	Financial stability and cost management protect the State and members from large premium increases. Maintaining a strong reserve balance enables the Plan to invest in initiatives to improve health and experience while managing future cost increases and cash flow. The Plan's expense trend has been at or below the medical Consumer Price Index for the last four fiscal years and reserves at the end of FY 2014 were approximately four times the targeted amount. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014 and forgo premium increases for the State and members in 2015.



STRATEGIC INITIATIVES

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Improve Members' Health	Maximize Patient Centered Medical Home (PCMH) Effectiveness	The Patient Centered Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting) and communication to transform primary care to include population health management. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.	• Support providers and practices in serving as PCMHs through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated PCMH groups
			• Groups will be identified for support/ partnership (directly or through vendor partners) based on willingness to engage and opportunity for improved patient outcomes based on review of available clinical measures
			• Develop metrics and benchmarks to demonstrate the impact of improved care delivery and coordination such as medication adherence, reduced ED use, hospital readmissions and nationally benchmarked HEDIS measures
			• Design and communicate incentives and other benefit designs that encourage members to have designated PCMHs serve as their primary care provider
				• At the heart of the PCMH are the patient and the primary care physician who serves as the key to better coordination of care and patient engagement
				• For 2014, 98% of members in the 80/20 and 99% of members in the CDHP plans selected a primary care provider
				• Increasing the number of primary care providers that are PCMHs will help ensure timely access to care and increase the focus on quality of care indicators such as:
				  • Diabetes HbA1c testing rate is 88.9% while the national benchmark at the 75th percentile is 91% and at the 90th percentile is 94%
				  • Cholesterol LDL-C testing rate is 81.3% while the national benchmark at the 75th percentile is 87% and at the 90th percentile is 89%

	Assist Members to Effectively Manage High Cost High Prevalence Chronic Conditions	Focused programs designed to assist members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. This includes a focus on members with multiple and complex chronic conditions.	• Develop chronic care management programs focused on high volume and high cost conditions where there is opportunity to collaborate with providers to improve both quality of care and member engagement • Collaborate with other state entities and stakeholders, including the NC Department of Health and Human Services, on addressing how to improve these conditions across the state	• Members with at least one chronic condition account for 76% of total cost of care (Non-Medicare) • Prevalence of high cost chronic conditions (for actives): Hypertension 25%, Asthma/COPD – 10%, Diabetes – 9%, CAD – 3% • Members with one or more chronic conditions utilize $7,664 of services while healthy members (those without a chronic disease related claim) utilized about $1,283, almost 7 times the cost of those with a chronic condition • 2013 medication adherence rates for active members with diabetes is 46%, hypertension is 57% and high cholesterol is 65%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	Offer Health-Promoting and Value-Based Benefit Designs	Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek treatment from high quality, cost effective providers	• Offer benefit designs that provide no cost access for preventive care, encourage utilization of PCMHs and use of high quality primary care providers, encourage healthy behaviors and engage members • Consider additional value-based benefit designs that offer quality and cost options around providers, treatments and medications • Incent members to make long-term healthy lifestyle choices and more effectively manage chronic disease	• Access to high quality care at cost effective settings helps sustain health and allow for management of chronic disease • When offered a premium credit, 84% of active members selecting the CDHP and 80/20 plan options completed a health assessment, chose a PCP and attested they did not smoke or were enrolled in a smoking cession program
	Promote Worksite Wellness	Any employment based activity or employer sponsored benefit aimed at promoting healthy behaviors (primary or secondary prevention). These are programs that require longer time horizons by which to measure results and impacts.	• Using the NC Health*Smart* program, partner with state agencies to influence environmental and workplace policies and tailor programs suited to the different strata of membership across the state • Develop programs and approaches that ensure the continuous engagement of members throughout the year	• Creating a culture of wellness requires the participation and support of the employer • National data suggests that worksite wellness programs help employees feel more valued • 45% of employees say these programs encourage them to stay with their employer

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Improve Members' Experience	Create Comprehensive Communication & Marketing Plan	Providing members with materials they can understand to help them effectively utilize their health benefits. Communicating regularly, not just at Annual Enrollment, to allow members the opportunity to maximize their experience and improve their access to the health care services available to them.	• Develop a comprehensive and continuous communication strategy, including print, email, web-based and mobile applications and media, regarding benefit plan options, how to get the most value out of the benefit programs and explain the value of the benefits that are offered, including: ○ Improve member contact information ○ Develop a branding campaign in coordination with the Department of State Treasurer ○ Regularly meet with provider community to distinguish Plan services from BCBSNC services • Demonstrate the value of and promote Plan offerings	• Health benefits are utilized throughout the year and therefore, regular benefits communications will assist members with benefit questions and managing their care • There are opportunities to use online communication channels as less than 1% of members access Health*Smart* resources online • Over 80% of retired members prefer written materials while active members prefer online communications. This demonstrates the need for a variety of communication channels
	Improve the Member Enrollment Experience	Members are able to enroll in and access the benefits they choose and their premium credits are accurately reflected. Enrollment tools meet current technology standards. Streamline customer service calls and online access.	• Develop a consistent and stable platform for members' enrollment experience • Provide a customer service call center to provide members with timely and accurate enrollment and benefit information • Ensure that enrollment data is accurately collected, maintained and transmitted in a timely manner • Where possible, provide single sign-on from the originating secure site to other sites to eliminate the need for multiple passwords and user IDs	• Enrollment is the gateway to the provision of benefits and it is imperative that the member's enrollment experience is as simple as possible and that enrollment information is accurately captured, displayed and transmitted to ensure access to appropriate benefits and to improve the trust of members • Having multiple contact numbers and login IDs can be a barrier to access and timeliness of service • Improving member experience can enable increased engagement
	Promote Health Literacy	Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions.	• Develop and market tools and resources, particularly web-based and mobile applications, that provide cost and quality transparency metrics and assist members in making informed choices on treatment options, cost, provider selections, and site of service	• Providing tools to access high quality, site appropriate, and low cost care encourages improved health outcomes, raises member satisfaction, and reduces Plan cost growth • Only 0.2% of members access the provider portal, which houses the current transparency tools • Web-based and mobile platforms improve accessibility to information

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Ensure a Financially Stable State Health Plan	Target Acute Care and Specialist Medical Expense	The management of specific categories/ treatments of care that exceed the Plan forecast and/or medical expense trends. The management of member out-of-pocket costs in high cost services and care settings such as hospitalizations and specialized medical care. The management of fraud, waste, abuse and overuse of medical services.	• Develop and implement targeted programs or benefit designs that specifically address the following:
			  ○ Appropriate use of emergency rooms and urgent care centers
			  ○ Avoidable inpatient admissions, readmissions, duplicative care
			  ○ Use, costs and/or site of service for specialty medical services
			  ○ Implement targeted programs focused on reducing fraud, waste, abuse and overuse of medical services.
			  ○ Reinforce payment for necessary care only and minimize payment for unnecessary, duplicative care (e.g., never events)
				• Hospital inpatient costs averaged $3,266 per day in 2013 and represented $612 million in spending (17.5% of total)
				• The average cost of a hospital stay for Plan members was $15,553 in 2013
				• Emergency room costs represent another $146 million in medical costs (4.2%)

	Target Pharmacy Expense	The management of specialty medications across medical and pharmacy spend as well as fraud, waste, abuse and overuse of pharmaceuticals	• Implement targeted programs or benefit designs that manage the cost, use, and/or site of service of specialty medications • Implement targeted programs focused on reducing fraud, waste, abuse and overuse of pharmaceuticals	• Pharmacy costs are 29% of total plan medical costs • 2.6% of non-Medicare membership uses specialty medications under the medical benefit which accounts for 6.7% of total plan (non-Medicare) medical payments • Medical specialty pharmacy trend is 11.3% • <2 % of members use specialty medications under the pharmacy benefit which accounts for 22% of plan pharmacy cost. This is projected to be 50% by 2018. • Specialty pharmacy (pharmacy benefit) trend is currently 16%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Ensure a Financially Stable State Health Plan	Pursue Alternative Payment Models	Shift away from the current pay for volume approach in health care to paying for outcomes based on evidence based metrics. Utilize the spectrum of alternative payment strategies, ranging from PCMH to pure capitation, to more efficiently compensate providers to provide care in the most effective setting. Take a long-term, prospective view to improve member health to manage cost growth versus only short-term price reductions.	• Partner with current and future third party administrators (TPA)/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in North Carolina • Partner with other payers, where appropriate, to implement consistent approaches to alternative payment strategies throughout North Carolina • Engage with providers who are able to work directly with the Plan on value based payments and metrics	• Moving away from pure fee for service provides an incentive to focus on better coordination and effective care • 15.6% of hospital admissions had a readmit within 30 days • Average inpatient cost per day has increased by 4.4% over the past year
	Ensure Adequate, Stable Funding from the State of North Carolina	Work to secure the necessary stable funding sources by maintaining stakeholder confidence in and support for the Plan.	• Act in an open and transparent manner as appropriate in all interactions with the Governor, Office of State Budget and Management, General Assembly, Fiscal Research Division, state agencies and the public • Use all reasonable tools, processes and assumptions to accurately forecast revenues, expenses, and required premium contributions • Proactively work with the Governor, Office of State Budget and Management (OSBM), General Assembly, and the Fiscal Research Division (FRD) to protect the Plan's reserves and ensure adequate funding is appropriated each year to enable the Plan to achieve its mission • Partner with employee and retiree stakeholder groups to support the Plan's funding and legislative requests	• Maintaining the confidence in and support for the Plan by key stakeholders in a time of fiscal challenges and competing priorities will help ensure adequate funding is available over the long term, thereby producing a stable financial environment to support the mission of the Plan • Maintaining stable funding helps prevent against benefit erosion and allows the Plan to offer and evaluate the cost-effectiveness of alternative benefit designs, incentives and pilot programs as well as invest in programs and initiatives to improve the member experience and access to quality care

STRATEGIC MEASURES OF SUCCESS

Priority	Description	Metric	Rationale	Timeframe/Baseline
Improve members' health	PCMH utilization	Increase % of members receiving care from a NCQA recognized PCMH	PCMH practices provide an opportunity to improve care and care coordination for members	Annual comparison to year-end 2013
	Quality of care measure	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards	Monitoring delivery of clinical quality of care standards ensures Plan members are receiving quality health care	Annual comparison to year-end 2013
	Worksite wellness	Increase number of worksites offering worksite wellness initiatives	The number of worksites offering onsite wellness initiatives are a proxy for measuring a culture of wellness across State agencies	Annual comparison to year-end 2013
Improve members' experience	Customer satisfaction	Maintain or improve overall customer satisfaction score	Overall customer satisfaction is a proxy to monitor the overall Plan's effectiveness	Annual comparison to year-end 2012
	Annual Enrollment service level agreements (SLA)	Improve Annual Enrollment customer service SLAs	Enrollment is the gateway to the provision of benefits and an opportunity to instill trust in the member	Annual comparison to year-end 2013 (from October 2013 enrollment period)
	Member engagement	• Increase in the number of active members registered as users on TPA's website • Increase in the usage of TPA's provider search and transparency tools by active members • Increase in attendance at educational roadshows	Measuring members engaged in communication and health literacy efforts is a proxy for measuring the Plan's effectiveness at targeted member outreach	Annual comparison to year-end 2013
Ensure a financially stable State Health Plan	Net income/loss	Net income/loss actual at or above certified or authorized budget (as forecasted by actuaries) for plan year	Provides a comprehensive measure of Plan finances	Annual comparison
	PMPM claims expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	Claims expense is the main variable driving financial performance	Annual comparison
	Member cost-sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	Member cost-sharing is an important component in member affordability	Annual comparison to year-end benchmark

Note: All years are based on the calendar year ending in December, unless specifically noted as fiscal year (FY). Measures will be reported as part of the Plan scorecard and updates will be provided according to the financial reporting schedule.

VENDOR CONTRACT DEPENDENCIES

The following chart outlines the anticipated effective dates of new contracts as well as the optional renewal and termination dates for existing contracts that are important to the strategic plan. The timing of contract terminations and the length of time required to procure new vendors may impact the strategic initiatives as well as the sequence and timing of the initiatives. The estimated length of time to change vendors or make significant changes to existing contracts can take between 18 and 24 months including development, procurement and implementation. The Board is required to approve all contracts with a value of $500,000 or more.

Vendor dependencies and contract requirements will be continuously assessed as the details of the deliverables of specific projects and programs are developed. Depending on the final detailed design of each initiative as well as other contracting or vendor selection or negotiation issues, the vendor contract reference chart and the timelines associated with each initiative outlined in the roadmap on the following pages could be modified. In addition, the chart below only reflects active contracts. Additional vendor contracts may be required in order to implement the initiatives, and Board approvals will be acquired as needed.

Vendor Contract Reference Chart

Category	2014		2015		2016		2017		2018	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
BCBSNC						12/31/16		12/31/17		12/31/18
Humana						12/31/16		12/31/17		12/31/18
UnitedHealthcare						12/31/16		12/31/17		12/31/18
Medco / Express Scripts				12/31/15		12/31/16				
ActiveHealth Management		12/31/14		12/31/15						
COBRAGuard						12/31/16		12/31/17		12/31/18
Benefitfocus				Termination Expected by 12/31/15		12/31/16		12/31/17		12/31/18
Aon-Hewitt		8/31/14								

New Contract Option to Renew Contract Contraction Terminates

STRATEGIC ROADMAP

July 2014 – December 2018

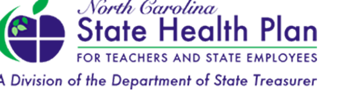
Background and Definitions

The charts on the following pages outline the high level roadmap for each of the strategic initiatives included in the strategic plan Each chart includes a brief description of the project or program, any associated contract decisions and/or benefit approvals, an estimated launch date, and an indication of the magnitude of impact relative to the membership. Although not necessarily described in the charts, each of the projects or programs include planning (discovery interviews, market research, synthesis, and gaining consensus), building (developing detailed designs, acquiring necessary approvals, contracts, staff, and training), and implementation (communication, launch, and ongoing monitoring and management). Details on specific programs or benefit designs will be communicated as proposals are developed. The purpose is to organize the major work streams and key milestones, particularly those that will require Board approval. The Plan leadership team will provide updates to the Board proactively on progress as appropriate and as needed.

In addition, the estimated milestones take into consideration the dependencies on vendor contracts based on what is known at the time of planning. The dates on the charts that follow are **not intended to communicate actual contract dates or otherwise indicate that Board approval will be required for every contract decision.** As a planning document, the charts are intended to indicate the possibility of vendor contracts or Board action and final decisions and actions will depend on the details of each initiative.

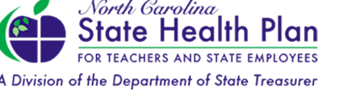
The following reference table outlines the elements of the work and timelines included in the charts:

Term or Key Indicator	Definition
Projects & Programs	Short description of the major work efforts that will be delivered in support of the initiative
	Possible Board benefit approval point. The need for any approvals will depend on the final detailed design of any new project or program.
	Possible contract decision point – reflects the anticipated point in time when a decision regarding contract extensions or amendments or Board approval of a new contract is required. Contract decisions may or may not require Board action. The need for any approvals will depend on whether it is a new contract with a value of $500,000 or more.
◆	Indicates the estimated launch date for small or moderately sized projects or programs. For example, pilots, regional programs or projects impacting a relatively small number of Plan members.
◆	Indicates the estimated launch date for large, statewide projects or programs. For example new products or a disease management program available statewide that impacts a large number of members.



Strategic Priority: Improve Members' Health

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
PCMH	**PCMH Pilot:** PCMH pilots established with at least 4 health care systems or provider groups. The goal of the pilot is to identify a statewide standard for the PCMH model, to inform the next iteration of the Plan's contract with its population health management vendor and to assess the readiness of these health care systems for alternative payment methods.					
	PCMH Model: Implementation of the PCMH model statewide. This will take place through the contract with the population health management vendor.	Contract Decision- PHMS				
High Prevalence Conditions	**High Prevalence High Cost Care Management:** Develop and implement a high utilizer care management/coordination plan for members with a diagnosis of diabetes, asthma/COPD, hypertension or CAD in partnership with the Plan's population health management vendor. The intent of the initiative is to promote the delivery of appropriate and timely care within appropriate settings.					
	Chronic Pain Pilot: Implement a new program designed to identify and address prescription abuse, improve the safety of members who are taking narcotics and identify care management options.					
	Transition of Care Program: Target high priority members who are transitioning out of the hospital for care management to assist in reconciling prescriptions post discharge (Medication Therapy Management – MTM), coordinating follow -up appointments as necessary and to providing education and information on conditions. This will be accomplished through the contract with the population health management vendor.	Contract Decision - ADT feeds				
Value-Based Benefits	**Value Based Benefit Design:** Implement the next generation of wellness activities, premium credits, and incentives to increase member engagement and accountability, improve medication adherence, reduce waste and encourage the use of quality providers.					
Worksite Wellness	**Wellness Champions Pilot:** Develop a network of wellness champions within worksites to lead employees in worksite wellness initiatives. The Plan will provide incentives that reward those worksites with high levels of participation as well as support worksite with resources like speakers and toolkits.					
	Multipronged Three County Pilot: A three pronged, two year pilot in Greene, Jones and Lenoir counties aimed at addressing the high prevalence high cost chronic conditions of diabetes, asthma, COPD, hypertension, CAD, and stroke. The Plan and its vendors would help develop capacity to implement wellness initiatives within worksites in three counties, develop provider engagement with Plan membership and empower members in seeking appropriate health care and leveraging community resources.					



Strategic Priority: Improve Members' Experience

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Communication & Marketing	**Coordinated Communication Campaign:** Implement a communication approach for Retiree Health Benefits that is coordinated with the Retirement System and the Department of State Treasurer.		◆			
	Medicare Primary Communication: Enhance current Medicare Primary learning module and develop additional outreach strategies.		◆	◆	◆	
	Active and Non-Medicare Primary Communication: Develop learning module for Active and non-Medicare Primary members to enhance their health literacy and understanding of Plan Benefits.		◆	◆	◆	
Enrollment Experience	**New Eligibility and Enrollment vendor:** Transition all eligibility and enrollment services to a new vendor no later than July 1, 2015. In order to launch the new services all testing must be completed by March 31, 2015, and the communication plan with members, vendors and other stakeholders completed by December 31, 2014.	Contract Decision	◆			
	Annual Enrollment and Benefit Design Communication: Implement a comprehensive communication and marketing campaign each year regarding Annual Enrollment and benefit designs. Focus campaigns to emphasize the healthy activities required to earn premium wellness credits and value-based designs.		◆	◆	◆	◆
Health Literacy	**BlueConnect Launch:** BCBSNC is implementing a new member web portal in January 2015. Partner with BCBSNC to develop a communication strategy to increase engagement and utilization with the new functionality.	◆				
	Transparency & Literacy Tools Program: Implement programs that promote and incentivize members to utilize web-based transparency tools for identifying high quality, cost effective providers; calculate their best plan options based on expected utilization; and identify resources to assist with chronic conditions.			◆		
	Incentive Rewards Program: Implement a program that rewards members for healthy lifestyles, use of preventive benefits, and benefit engagement. An example of a potential reward is a Fitbit® for participating in a walking program or engaging with a health coach.				◆	

Strategic Priority: Ensure a Financially Stable State Health Plan

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Acute Care and Specialists	**Avoidable Admissions and Emergency Department Visits:** Implement a telehealth option to provide a less costly alternative to an ED visit but that also provides the member with direct and immediate access to a physician.	➔	◆			
	Place of Service: Incent members through benefit design to utilize the appropriate provider in the most cost effective setting for health care services. For example, incent members to choose a location without an associated facility fee.	➔	◆			
Pharmacy	**Specialty Pharmacy Management:** Implement programs that encourage the cost effective use of specialty pharmacy drugs including member and provider incentives regarding drug infusion site of care, equity in member cost share across pharmacy and medical benefits, and utilization management.	➔	◆			
	Enhanced Fraud Waste & Abuse Program: Replace the high utilization program, which restricts a member to one pharmacy due to the high utilization of targeted drugs (controlled substances and muscle relaxants) with a comprehensive Enhanced Fraud, Waste and Abuse Program. The Enhanced Program includes a review of both medical and pharmacy claims to accurately identify members who meet the robust criteria for restriction to one pharmacy and up to two prescribers for controlled substances and other drugs of abuse. The goal is to decrease fraud, waste and abuse (which includes improper use) of controlled substances and other drugs of abuse.		◆			
Alternative Payment Models	**Alternative Payment Models:** Implement alternative payment models with 2 to 3 accountable care organizations (ACOs) and then expand.	◆		◆		
Adequate, Stable Funding	**Communication with State Government Leadership:** Provide the Governor, General Assembly and other key stakeholders with regular updates and targeted communications on the Plan's strategic plan and financial results as well as policy and programmatic priorities through contact with the Office of the Governor, committees and individual members of the General Assembly, leadership staff, OSBM, FRD and state agencies.	◆	◆ ◆	◆ ◆	◆ ◆	◆ ◆
	Legislative Agenda: Develop and communicate funding requirements and requests for statutory changes for the long and short sessions to address the Plan's administrative, financial and policy needs and provide information, actuarial notes, and educational sessions as needed and requested.		◆	◆	◆	◆

LIST OF ACRONYMS

ACO	Accountable Care Organization
ADT	Admissions, Discharge and Transfer
BCBSNC	Blue Cross Blue Shield of North Carolina
CAD	Coronary Artery Disease
CDHP	Consumer-Directed Health Plan
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
FRD	Fiscal Research Division
HEDIS	Healthcare Effectiveness Data and Information Set
MTM	Medication Therapy Management
NCQA	National Committee on Quality Assurance
OSBM	Office of State Budget and Management
PCHM	Patient Centered Medical Home
PCP	Primary Care Physician
SLA	Service Level Agreement
TPA	Third Party Administrator